



**UK Focal Point
On Drugs**

United Kingdom Drug Situation

2015 EDITION

UK Focal Point On Drugs

Annual Report to the European Monitoring
Centre for Drugs and Drug Addiction (EMCDDA)



Public Health
England



The Scottish
Government



Department of
Health, Social Services
and Public Safety

as Riada
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poblí
Láinnseirbhís
Piontú, Resydenter Heisin
an Fowlk Siccar



Llywodraeth Cymru
Welsh Government



Home Office

United Kingdom drug situation: Focal Point Annual report 2015

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The United Kingdom Focal Point on Drugs

The United Kingdom (UK) Focal Point on Drugs is based at Public Health England (PHE). It is the national partner of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and provides comprehensive information to the Centre on the drug situation in England, Northern Ireland, Scotland and Wales.

The Focal Point works closely with the Home Office, other government departments and the devolved administrations (DAs). In addition to this annual report, it collates an extensive range of data in the form of standard tables (STs) and responses to structured questionnaires (SQs), which are submitted regularly to the EMCDDA. It also contributes to other elements of the EMCDDA's work such as the development and implementation of its five key epidemiological indicators, the Exchange on Drug Demand Reduction Action (EDDRA) and the implementation of the Council Decision on New Psychoactive Substances (NPS).

Further information about the UK Focal Point, including previous annual reports can be found on the Focal Point website at <http://www.nta.nhs.uk/focalpoint.aspx>

The EMCDDA's website is www.emcdda.europa.eu

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Technical Notes

Standard Tables

References in the text to Standard Tables (sometimes abbreviated to ST01, ST02 etc.) are to standardised reporting formats specified by the EMCDDA. All National Focal Points provide data using these Standard Tables in order to facilitate the collection of information in a consistent and comparable format across Europe. Information from the standard tables referred to in this report is published alongside the report on the Focal Point webpage. A list of standard tables is included in Part C of this document. The standard tables usually include the source of the data and details of methodology.

References to Specific Drugs

Cocaine. Where appropriate, this report distinguishes between 'cocaine powder' and 'crack cocaine'. When the word 'cocaine' is used it should be interpreted as meaning both forms of the drug.

Amphetamine(s). The term used in the text is the same as that used in the survey or study being described. In the UK methyl amphetamine is the term used in legislation for what is more generally known as methamphetamine.

Ecstasy. The term refers to MDMA in any form.

Use of term 'significant'

When the word significant is used it should be interpreted as meaning statistically significant at the 5% level or better.

Reference to latest/most recent data

Where the terms latest or most recent are used they should be interpreted as meaning the most recent data with respect to the drafting of this report. Due to delays between writing and publishing this document, it is possible that newer data is released prior to publication which is not referred to in this year's report. Where data are being compared between each country of the UK, data from the most recent year where available for all four will be used. In some cases individual countries of the UK may have released information relating to more recent years; this may also be referred to.



The UK population was estimated to be 64.6 million according to the 2014 mid-year estimate. Eighty-four per cent (54.3 million) live in England, eight per cent (5.3 million) in Scotland, five per cent (3.1 million) in Wales and three per cent (1.8 million) in Northern Ireland.

Summary

Chapter 1. Drug policy

National Action Plans and Strategies

In its annual review of the drug strategy, the Home Office highlighted the continued focus on all three strands of the strategy: reducing demand, restricting supply and building recovery. It also emphasised key advances since 2010 and outlined priorities for the year ahead.

In Scotland, the *2015/16 Updated Guidance for Alcohol and Drug Partnerships (ADPs) on Planning and Reporting Arrangements* were published. In addition a new Recovery Outcomes Web (ROW) tool has been developed, which will form part of the new national Drug and Alcohol Information System (DAISy) expected to be operational in autumn 2016.

The Welsh Government published *Working together to reduce harm: Substance misuse strategy annual report – 2015*, which reviewed progress made towards the objectives cited in their substance misuse strategy. Priorities for the year ahead include the publication of the new 2016-2018 delivery plan and the commencement of work on the new substance misuse strategy for Wales 2018-2028.

In Northern Ireland, the third annual report of progress towards outcomes contained within the drug strategy, *New Strategic Direction (NSD) for Alcohol and Drugs Phase 2, 2011-2016*, was published. A final evaluation of NSD Phase 2 will be conducted in 2016/17 with consideration being given to a new strategy after this.

The Scottish Government and the National Assembly for Wales each commissioned and published their own expert reviews on new psychoactive substances (NPS) in 2015. Both reviews made a series of recommendations to their respective governments for tackling the harms caused by NPS, including working with the Home Office to create new legislation for a blanket ban of NPS across the entire United Kingdom (UK).

In July 2015 the Prime Minister commissioned a review into how best to support those suffering from long-term yet treatable conditions, such as drug and alcohol addiction, back into work or to remain in work.

Treatment funding

Expenditure on drug misuse services for adults in England in 2013/14 was £581.1 million, with a further £74.9 million being spent on services for young people.

Local authorities received a ring-fenced Public Health Grant of £2.79 billion for public health services in the 2015/16 financial year. A new condition was added to the grant to encourage local authorities to improve the take up of, and outcomes from, their drug and alcohol misuse treatment services.

At present there is a consultation on the proposed allocation formula which will be used to calculate funds for 2016/17. New funding allocations will be announced in due course.

Chapter 2. Legal framework and drug law offences

Changes to drug misuse legislation

The Government has set out the limits for the maximum blood concentrations for 16 specific substances under the new drug driving legislation *the Drug Driving (Specified Limits) (England and Wales) Regulations 2014*. Limits are specified for eight illicit drugs such as cannabis, heroin and cocaine, and eight medicines, which are sometimes abused. The new regulations came into force in England and Wales in March 2015.

Amendments to the *Misuse of Drugs Act 1971* have been made so that the following substances have been classified as Class A under the Act:

- the NPS known as MT-45 and 4,4'-DMAR;
- the synthetic opioid AH-7921;
- the LSD-related compounds commonly known as ALD-52, AL-LAD, ETH-LAD, PRO-LAD and LSZ; and
- the compounds captured by the extended definition of tryptamines

On 30 November 2015, ketamine became a Schedule II controlled drug under the *Misuse of Drugs Regulations 2001*.

The following compounds and their simple derivatives were put under a Temporary Class Drug Order (TCDO):

- ethylphenidate;
- 3,4-dichloromethylphenidate ('3,4-DCMP');
- methylnaphthidate ('HDMP-28');
- isopropylphenidate ('IPP' or 'IPPD');
- propylphenidate;
- 4-methylmethylphenidate ('4-Me-TMP'); and
- ethylnaphthidate ('HDEP-28')

There have been also a number of changes in legislation over the last year which aim to restrict the supply of illicit substances, including the introduction of the *Serious Crime Act 2015* to tackle the trade in cutting agents; making it an offence to throw any article or substance into a prison; and the strengthening of the *Proceeds of Crime Act 2002*, which has enabled assets held by defendants and others to be frozen and recovered, and traffickers prosecuted more quickly.

Legislative changes aimed at increasing the availability of naloxone came into force in October 2015.

Legislation designed to control new psychoactive substances

The *Psychoactive Substances Bill* has been introduced in Parliament and, subject to Parliamentary approval, this legislation will ban the sale, supply, production and distribution of psychoactive substances for human consumption. Other initiatives at a local level have also been introduced to control the use of NPS, such as the banning of consumption of intoxicating substances in public spaces.

With the *Criminal Justice and Courts Act 2015*, additional powers have been given to prison governors to stop the use of drugs in prison. These powers include testing for non-controlled drugs, such as NPS, and stiffer penalties on those suspected of being involved in smuggling NPS into prisons.

Chapter 3. Prevalence, availability and relative importance of different drugs

Cannabis

The long-term declining trend in the prevalence of cannabis use seen in surveys conducted on the general population as well as in results from school surveys shows signs of levelling out. The proportion of cannabis users who report having used cannabis in the last month has continued to reduce in recent years.

Stimulants

Cocaine (in powder form) remains the most prevalent stimulant in the UK followed by ecstasy (MDMA). While overall prevalence of cocaine is lower than a few years ago, the proportion of users aged 35-44 has been rising. There is a long-term downward trend in the proportion of last year users reporting having used in the last month for both cocaine and ecstasy.

Opioids

UK Focal Point estimates there are about 370,000 problem drug users in the UK who are mainly opioid users. There is an increasing practice of prescribing opioids for pain-relief. The *Crime Survey for England and Wales* reported that 5.4% of adults aged 16 to 59 had misused a prescription-only painkiller not prescribed to them in the last year.

Injecting drug use

There are current concerns about increased injection of amphetamine-type stimulants including NPS and synthetic cathinones. In Edinburgh, injecting of ethylphenidate-based NPS with brand names such as Burst and Blue Stuff has been associated with the spread of infection. There is an ongoing decline in the numbers of drug users injecting opioids and crack-cocaine in England.

Chapter 4. Prevention

Environmental prevention

In England and Wales a new legislation regulating the maximum blood concentration allowed for a selection of legal and illicit drugs for drivers came into force in March 2015.

In Scotland the legal blood alcohol limit for drivers has been lowered to 50mg in every 100ml of blood. The Northern Ireland Assembly is considering introducing a similar measure from mid-2016.

In March 2015 the UK Parliament approved the introduction of standardised packaging for tobacco products. The regulation will take effect in May 2016.

Smoking in private vehicles carrying children became illegal in October 2015 in England and Wales.

Universal prevention

In 2015 the Advisory Council on the Misuse of Drugs (ACMD) Recovery Committee published a document aimed at supporting policy-makers and practitioners working in prevention as well as providing recommendations.

In November 2014 Public Health England (PHE) launched Rise Above, an interactive online resource for young people; the service was activated in February 2015. The website not only provides information but also supports a range of situational tools and skills-based resources aimed at helping young people to make positive choices for their health.

Chapter 5. Drug-related treatment: treatment demand and availability

Treatment Demand Indicator

There were 100,456 treatment presentations in the UK in 2014 (those starting a new treatment episode).

Just over half (52.1%) of all treatment presentations in the UK were for primary opioid use. However, these were disproportionately distributed, accounting for over two-thirds (68.0%) of presentations of previously treated clients in comparison to just under one-quarter (23.2%) of those who had never previously received treatment.

Just over one-quarter (26.0%) of all treatment presentations were for primary cannabis use. Despite recent rises in the percentage of first ever treatment presentations for cannabis, between 2013 and 2014 the proportion fell from 48.6% to 46.6%.

The proportion of all treatment entrants presenting for primary cocaine remained stable at 9.4%, the same level seen in 2013.

In England, between 2011/12 and 2012/13 there was a steep increase in the number of clients aged 18 or over presenting to treatment for any club drug, from 2,675 to 3,536, which has stabilised in 2013/14 ($n = 3,543$). This represents five per cent of those presenting to treatment in 2013/14.

The number of young people (aged 17 years and under) attending specialist misuse services for drugs or alcohol in England decreased by 4.5%, from 20,032 in 2012/13 to 19,126 in 2013/14.

Treatment Outcomes

In England, amongst clients who received a review in 2013/14, users of crack cocaine only and cocaine powder were most likely to be abstinent at treatment review (60% and 65% respectively). Forty-eight per cent of opioid only users in 2013/14 were abstinent at the time of treatment review. In 2013/14 the number of successful completions in England remained stable at 15% of the total number of people in treatment.

Analysis of treatment outcomes data in Wales showed that on exit from treatment in 2014, the average number of days of using for primary heroin users had decreased by 61.8%. Furthermore, 59.1% of primary heroin users had been abstinent from heroin use in the 28 days prior to treatment exit.

New developments

In 2014 PHE, on behalf of the departments of health in England, Scotland, Wales and Northern Ireland, held a consultation regarding whether the 2007 *Drug Misuse and Dependence: UK Guidelines on Clinical Management* could benefit from being updated. The majority of responses received by the consultation were in favour of an update and consequently a review of the evidence is currently being conducted. Updated guidelines are expected to be published in early 2016.

In November 2014, PHE published a toolkit to help local authorities and National Health Service (NHS) England respond to the use, and associated problems, of NPS in their area. The toolkit provided advice, resources and points for consideration across multiple factors including: tackling supply and use; prevention; NPS interventions and treatment; NPS in prisons; and competence in working with NPS users.

In March 2015, project NEPTUNE (Novel Psychoactive Treatment UK Network) also published new guidance designed to increase the confidence and skills of clinicians in: the detection and identification of club drugs and NPS being used; assessment of the associated harms; clinical management of acute and chronic harms; and delivering harm reduction interventions.

Chapter 6. Drug-related infectious diseases and other drug-related harms

The prevalence of HIV infection amongst people who inject drugs (PWID) remains fairly stable. In 2014, it was one per cent in England, Wales and Northern Ireland amongst PWID taking part in the Unlinked Anonymous Monitoring (UAM) survey. Similarly, the prevalence of hepatitis C amongst PWID has remained relatively stable over the last decade and in 2014 it was 49% amongst those participating in the UAM survey. The prevalence of hepatitis B has remained stable in recent years and is half the level that was recorded a decade ago (14% in 2014 compared to 28% in 2004). This decrease is possibly due to the increased uptake of the hepatitis B vaccine amongst injecting drug users.

There have been increasing concerns related to the harms associated with the practice of chemsex, especially among men who have sex with men (MSM). The use and injection of crystal methamphetamine and mephedrone and the consumption of GHB/GBL before or during planned sexual activities are thought to be a factor in the increased transmission of a number of sexually transmitted infections, HIV and viral hepatitis among this population sub-group.

Prevalence of hepatitis C among people who inject image and performance enhancing drugs (IPEDs) was lower than that found among participants in the main UAM survey targeted at PWID; however, it was still higher than observed in the general population, whilst prevalence of HIV was similar in both groups. This raises concerns regarding the risks and harms associated with the transmission of drug-related infectious diseases among IPED injectors.

New developments

In Northern Ireland a new pilot project is being undertaken in 2015 to survey the blood-borne virus (BBV) status of people using IPEDs who are accessing pharmacy needle exchange sites. Health Improvement Scotland and NHS Scotland have published new guidelines for cost-effective treatment of hepatitis C. In Wales, in May 2015 the new *Together for Health – Liver Disease Plan* was published, which sets out key service issues, priorities and assurance measures in preventing disease and improving treatment services.

Chapter 7. Drug-related deaths

Changes to methodology

UK figures under the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) definition are, from 2015 reporting year onwards, counting deaths from England and Wales according to year of occurrence. As such, 2013 is the latest available reporting year by this definition, as this is the most recent year where it can be assumed the large majority of relevant deaths in England and Wales have now been registered. For the Office for National Statistics (ONS) and Drug Misuse definitions, the figures continue to represent registrations in the most recent year (2014).

A further methodological change in this year's reporting is that deaths with an underlying cause of death of X44, X64 and Y14 alongside relevant T-codes have been incorporated into UK figures reported using the EMCDDA definition. Due to historical coding practice in England and Wales, this has substantially increased the number of deaths counted under this definition. Also, due to changes in reporting, a small number of deaths registered in England and Wales where the person was not resident in either country are no longer included.

Drug-related deaths

Using the EMCDDA definition, the total number of drug-related deaths registered in the UK during 2013 was 2,449, a 12% increase from 2012 and the highest number reported to date. Numbers of deaths using the Drug Misuse definition and the much wider ONS definition showed increases in 2014 compared to 2013. However, Wales is an exception to the UK trend, with a reported 16% fall in deaths registered using DMD.

Combined England and Wales figures for 2013 using the EMCDDA definition saw an 18% increase in the number of drug-related deaths compared to 2012, while Scotland experienced a fall of 6%, and Northern Ireland a rise of 48%.

In 2013, the average age of those dying was 41.6 years, with males tending to be about five years younger than females (40.5 years and 45.1 years respectively). The average age at death has increased from 37.6 years in 2004.

Overall, the largest proportion of deaths occurring in the UK in 2013 occurred in the 40 to 44 years age-group (433, or 18% of deaths) and deaths in this age group increased by 21% from the previous year ($n=358$). Compared to 2008, the number of drug-related deaths decreased for all age-groups below the age of 40 and increased for all age-groups above this point. An increase was seen in all age-groups in 2013 compared to 2012, with the exception of the 20-24 age-group.

Across England and Wales under the EMCDDA definition for 2013, there were 1,624 deaths counted which featured an opioid (87% of the total). As in previous years, the substance with the largest number of associated deaths was heroin ($n=792$). This represented a 30% increase compared to the 2012 figure but also a return to a level similar to that seen in 2008 ($n=798$). In 2013, the number of methadone deaths registered fell to 366, continuing the decrease observed since 2011 ($n=490$). Deaths mentioning cocaine increased again in 2013 (up 26% from the previous year). Deaths mentioning tramadol continued to increase greatly, by nine per cent between 2011 and 2012, and 33% between 2012 and 2013.

New developments

There has been growing concern regarding the harmful effects of new psychoactive substances across the UK. In March 2015 the synthetic stimulant 4,4'-DMAR became controlled as a class A drug after it was associated with 37 deaths across the UK. The Prisons and Probation Ombudsman also reported on an increased number of deaths in prison related to NPS between April 2012 and September 2014.

Chapter 8. Drug users in prison

The *Offender Rehabilitation Act 2014* (Her Majesty's Government, 2014) came into force on 1 February 2015. The former Probation Trusts were dissolved and their responsibilities were transferred to either the newly established National Probation Service, which is responsible for providing supervision to the highest risk offenders in the community, or the Community Rehabilitation Companies (CRCs), which supervise lower to medium risk offenders.

Data from the 2014/15 survey by Her Majesty's Inspectorate of Prisons (HMIP) show that 28% of male and 41% of female new arrivals at prison in England and Wales stated they had substance misuse needs. The HMIP Report also found that 32% of adult male respondents stated that illicit drugs were "easy" or "very easy" to obtain in their prison.

In England and Wales during 2014/15 the rate of drug misuse as reflected by those testing positive in mandatory drug tests was 6.9%. This was a decrease from the rate for the previous year of 7.4%.

Drug-related health responses

In April 2014 a new opt-out testing programme for blood-borne viruses was introduced in 11 prisons across England. In the first six months there was a near doubling of BBV testing, though the proportion of those testing positive remained stable, with 0.3% testing positive for HIV, 0.2% positive for hepatitis B and nine per cent testing positive for hepatitis C. It is hoped that opt-out BBV testing will be fully implemented across all prisons in England by 2016/17.

There were 872 Take Home Naloxone (THN) kits issued by prisons in Scotland in 2014/15 to persons at risk of opioid overdose. The total number of kits issued in Scottish prisons decreased by 18% in comparison to 2013/14.

In Wales one-fifth of male unique individuals issued with THN between 1 April 2013 and 31 March 2014 were issued with THN upon release from prison. When compared to national Area Planning Board (APB) provision, prisons are amongst the highest distributors of THN within Wales.

The availability of naloxone to prisoners in England has so far been limited. Naloxone has been made available to a limited extent in some prisons and there are proposals to pilot its use as part of the end-to-end approach to tackling addiction from custody into the community currently being tested in the north-west area.

New developments

The increasing presence of NPS within prison establishments is a growing concern. They have been linked to mental health problems and disturbed behaviour by prisoners and as such their use is having a dangerous impact on the security and order in prisons. In response to this, two new legislative changes have been enacted, the *Serious Crime Act 2015* and the *Criminal Justice and Courts Act 2015*. In addition, a new toolkit to support prison healthcare and custody staff to tackle NPS has been developed by PHE.

On 1 November 2014 two new licence conditions and supervision requirements, the Drug Appointment Condition and the Drug Testing Condition, became available to manage offenders in the community following their release.

Chapter 9. Drug markets

Seizures

In 2013/14 there was an increase in the number of seizures for all drugs, except cannabis and mephedrone. Despite the decline in the number of seizures, cannabis remained the most commonly seized drug by far, involved in around nine times as many seizures as cocaine powder, the next most commonly seized drug. The quantity of cannabis resin seized fell steeply by 91.6% driven by a substantial decrease in the quantity seized in England and Wales. Ketamine saw the largest increase in the quantity seized, rising 46% between 2012/13 and 2013/14.

Price/purity

Street-level price data from law enforcement sources suggest that the price of most drugs remained stable in 2014, although the retail price of both cannabis resin and sinsemilla rose by over 55%. The price of ecstasy per tablet also rose, despite a decline in the typical MDMA content per pill.

Having been low during both 2011 and 2012, heroin purity has risen over the last two years and is now higher than in 2010. The price per gram at street-level has also increased. However, the purity-adjusted price has fallen considerably from a peak of around £74 per gram in 2011 to around £45 in 2014 as a result of the increased quality of the substance typically being sold at street-level.

Cocaine powder purity in the domestic market has fallen slightly for the first time in five years, though it remains one and half times higher than the level seen in 2009. Conversely, the purity-adjusted price of cocaine has risen for the first time in five years.

Supply reduction activities

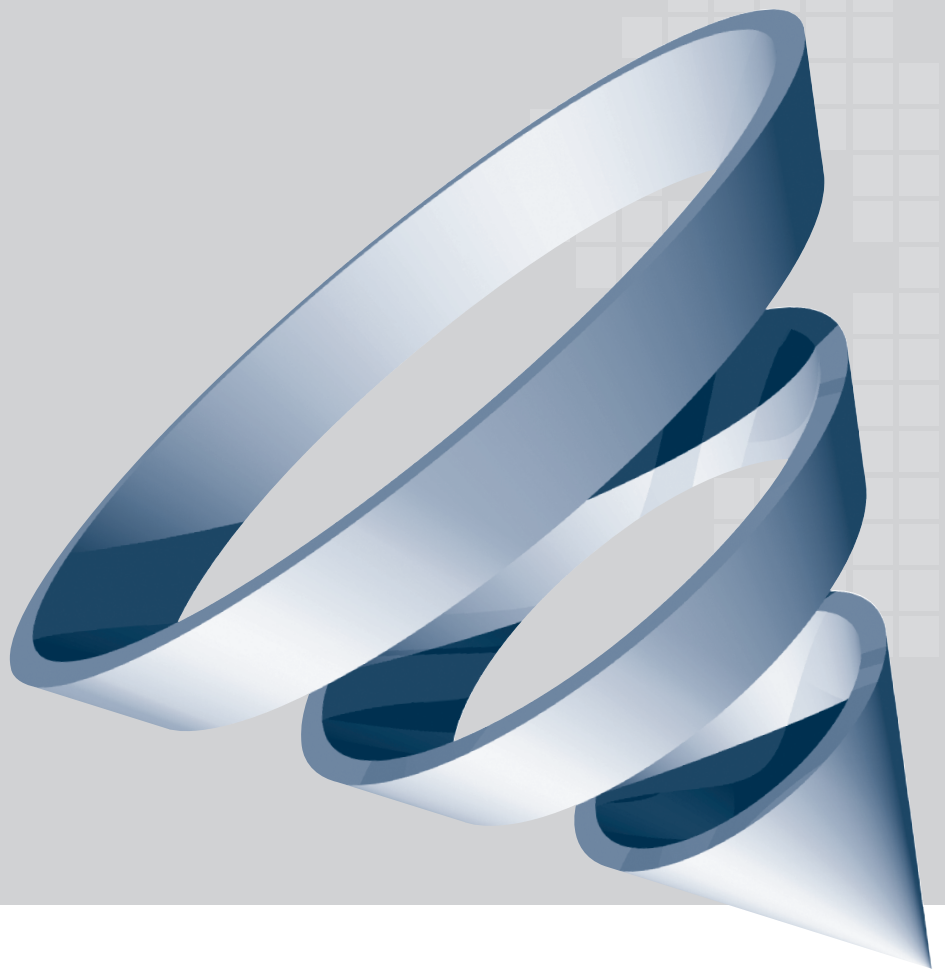
There have been a number of changes in legislation over the last year which aim to restrict the supply of illicit substances, including the introduction of the *Serious Crime Act 2015* to tackle the trade in cutting agents; strengthening of the *Proceeds of Crime Act 2002*, and a number of NPS and prescription medicines were permanently controlled under the *Misuse of Drugs Act 1971*.

New developments

British Organised Crime Groups (OCGs) are importing liquid amphetamine oil and wet base into the UK to be converted into amphetamine sulphate. This requires much less expertise than production from precursors and provides more diverse opportunities to conceal trafficking into the UK.

The Psychoactive Substances Bill has been introduced in Parliament and, subject to Parliamentary approval, this legislation will ban the sale, supply, production and distribution of psychoactive substances for human consumption.

Part A: New Developments and Trends



1. Drug policy

1.1 Introduction

The United Kingdom (UK) consists of England, Wales, Scotland and Northern Ireland. Eighty-four per cent (54.3 million) live in England, eight per cent (5.3 million) in Scotland, five per cent (3.1 million) in Wales and three per cent (1.8 million) in Northern Ireland. A number of powers have been devolved from the UK Parliament to Wales, Scotland, and Northern Ireland, but each has different levels of devolved responsibilities.

The UK Government is responsible for setting the overall strategic approach to reducing drug harms and for its delivery in the devolved administrations only in matters where it has reserved power. The *Drug Strategy 2010: Reducing demand, restricting supply, building recovery: supporting people to live a drug free life* (Her Majesty's Government, 2010) places a much greater emphasis than preceding strategies on supporting those who are drug dependent to achieve recovery, and also widens the focus of dependence to prescription and over the counter medicines and tackling emerging new psychoactive substances (NPS). Within the strategy, policies concerning health, education, housing and social care are confined to England; those for policing and the criminal justice system cover England and Wales; and the work of the Department for Work and Pensions (DWP) applies to England, Scotland and Wales.

The Scottish Government and Welsh Government's national drug strategies were published in 2008 (Scottish Government, 2008c; Welsh Assembly Government, 2008a), the latter combining drugs, alcohol and addiction to prescription drugs and over the counter medicines. Each strategy aims to make further progress on reducing harm and helping individuals recover from their drug problems. The Scottish and Welsh strategy documents are also accompanied by an action or implementation plan, providing a detailed set of objectives; actions and responsibilities; expected outcomes; and a corresponding timescale for delivery (Scottish Government, 2008c; Welsh Assembly Government, 2008b). Each plan reflects the devolution of responsibilities to the national government.

In Scotland, the *2015/16 Updated Guidance for Alcohol and Drug Partnerships (ADPs) on Planning and Reporting Arrangements* (Scottish Government, 2015e) aims to continue to support the embedding of outcomes-based planning and reporting at the local level. This guidance identified nationally agreed core outcomes and indicators that all ADPs are expected to deliver against.

Northern Ireland's strategy for reducing the harm related to alcohol and drug misuse, the *New Strategic Direction for Alcohol and Drugs*, was launched in 2006 (Department of Health Social Services and Public Safety Northern Ireland, 2006). The strategy contained actions and outcomes, at both the regional and local level, to achieve its overarching aims. A review of the strategy was conducted in 2010, and, after consultation, a revised strategy, the *New Strategic Direction for Alcohol and Drugs Phase 2, 2011-2016*, was launched in December 2011 (Department of Health Social Services and Public Safety Northern Ireland, 2011b).

The drug strategies in Wales and Northern Ireland are underpinned by performance management frameworks, including Public Service Agreements (PSAs) and associated sets of performance indicators, against which progress is measured.

1.2 National action plan, strategy, evaluation and co-ordination

1.2.1 Current national drug strategy

The UK Government is responsible for setting the overall strategic approach to reducing drug harms and it retains some reserved powers. The legal framework relating to the misuse of drugs, including the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971), is reserved to the UK Government, however some areas of policy including health, education, housing and social care only apply to England. Similarly, the role of the police and criminal justice system apply to England and Wales and the work of the DWP to England, Scotland and Wales. Each of the devolved administrations has produced their own drug strategy, which reflects their ideology and the devolution of responsibilities to the national government.

The UK Government continues to build on the *Drug Strategy 2010, Reducing demand, restricting supply, building recovery: supporting people to live a drug free life* (Her Majesty's Government, 2010), which was published in December 2010. The strategy places greater emphasis than preceding strategies on supporting those who are drug dependent to achieve recovery, and on the provision of the integrated support necessary to enable this, such as housing and employment. The strategy is divided into the three broad themes of reducing demand, restricting supply and building recovery, each with a number of objectives and proposed actions.

The two overarching aims of the strategy are to:

- reduce illicit and other harmful drug use; and
- increase the numbers recovering from their dependence

For the first time, the strategy widened its focus to include dependence on all drugs, including prescription and over the counter drugs, as well as tackling the emergence of NPS. It emphasised a shift in responsibility away from central government to locally led treatment plans, highlighting the creation of Public Health England (PHE) (see section 1.3.1). The strategy sets out the function of roles including Directors of Public Health and Police and Crime Commissioners, to support the shift of responsibility for health improvement to a local level. Furthermore, the strategy introduced new legal powers aimed at restricting the supply of drugs, including the introduction of Temporary Class Drug Orders (TCDOs) for NPS (see section 2.2.3) and new powers to seize cutting agents and precursor chemicals (see section 2.2.1).

The Home Office leads on the implementation of the strategy within England, and with regard to reserved matters elsewhere, and is supported by various departments and organisations including the DWP, the Department of Health (DH), the Department for Communities and Local Government (DCLG), the Department for Education (DfE), the National Crime Agency (NCA) and the Ministry of Justice (MoJ).

Scotland

The Scottish Government's national long-term drug strategy, *The Road to Recovery: A new approach to tackling Scotland's drug problem*, was published in 2008 (Scottish Government, 2008c). Central to the strategy is the concept of recovery and supporting people to live a drug-free life as active and engaged members of society. It continues to receive cross-party support from the Scottish Parliament. The strategy included multiple objectives across five principal action areas: promoting recovery; delivering the recovery model; prevention; enforcement; and children affected by substance misusing families.

The key priorities of the strategy are:

- better prevention of drug problems, with improved life chances for children and young people, especially those at particular risk of developing a drug problem, allowing them to realise their full potential in all areas of life;
- to see more people recover from problem drug use so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy;
- having communities that are safer and stronger places to live and work because crime, disorder and danger related to drug use have been reduced;
- ensuring that children affected by parental drug problems are safer and more able to achieve their potential; and
- improving the effectiveness of delivery at a national and local level

In Scotland, the *2015/16 Updated Guidance for Alcohol and Drug Partnerships (ADPs) on Planning and Reporting Arrangements* (Scottish Government, 2015e) aims to continue to support the embedding

of outcomes-based planning and reporting at the local level. This guidance identifies nationally agreed core outcomes and indicators that all ADPs are expected to deliver against. The Scottish Government has developed a Recovery Outcomes Web (ROW) tool, which will form part of the new national Drug and Alcohol Information System (DAISy), which aims to support the tracking of progress towards recovery for individuals in drug (and alcohol) services. DAISy is expected to be operational in autumn 2016.

Wales

The Welsh Government also published its long-term substance misuse strategy in 2008, *Working together to reduce harms 2008-2018* (Welsh Assembly Government, 2008a). The strategy combines drugs, alcohol and addiction to prescription drugs and over the counter medications. It has a clear focus on reducing the harms associated with substance misuse, citing its four aims as:

- reducing the harm to individuals (particularly young people), their families and wider communities from the misuse of drugs and alcohol, whilst not stigmatising substance misuse;
- improving the availability and quality of education, prevention and treatment services and related support, with a greater priority given than under the previous strategy to those related to alcohol;
- making better use of resources - supporting evidence-based decision making, improving treatment outcomes, developing the skills base of partners and service providers by giving a greater focus to workforce development and joining up agencies and services more effectively; and
- embedding the core Welsh Assembly Government values of sustainability, equality and diversity, support for the Welsh Language and developing user-focused services and a rights base for children and young people in both the development and delivery of the strategy

Since the launch of the strategy several accompanying shorter term delivery plans have also been published, the current version being *Substance misuse delivery plan 2013-2015* (Welsh Government, 2013). These delivery plans set out performance measures for each of the strategy's key action areas: preventing harm; supporting substance misusers to improve their health and aid and maintain recovery; supporting and protecting families; and tackling availability and protecting individuals and communities via enforcement activity. Progress of the delivery plan is monitored through an internal cross-Government Substance Misuse Programme Board, and an external Substance Misuse National Partnership Board (SMNPB) which meets three times a year. The final three year delivery plan 2016-18 is currently in development and consultation stakeholder workshops have been held. In August 2015, the National Assembly for Wales published the results of an inquiry into alcohol and substance misuse in Wales (National Assembly for Wales, 2015a). The report made a series of 21 recommendations to the Welsh Government, including suggested items for inclusion in the 2016-2018 substance misuse delivery plan. The new plan is expected to be subject to formal consultation in autumn 2015.

Northern Ireland

Northern Ireland's strategy, *New Strategic Direction for Alcohol and Drugs* (NSD), was launched in 2006 with a focus on reducing the harms related to alcohol and drug misuse (Department of Health Social Services and Public Safety Northern Ireland, 2006).

The NSD emphasised five supporting pillars for the strategy: prevention and early intervention; treatment and support; law and criminal justice; harm reduction and monitoring; and evaluation and research. It identified two themes: children, young people and families; and adults, carers and the general public, to be addressed across the five pillars as well as the three cross-sectional threads of workforce development, stakeholder involvement and vulnerable groups to run throughout the strategy.

The strategy contained actions and outcomes, at both the regional and local level, to achieve its overarching aims. A review of the strategy was conducted in 2010 and, after consultation, it was decided that rather than design an entire new strategy, a review, revision and extension of the strategy would

be more appropriate and would allow for the embedding of key principles. As such the *New Strategic Direction for Alcohol and Drugs Phase 2, 2011-2016*, was launched in December 2011 (Department of Health Social Services and Public Safety Northern Ireland, 2011b).

A number of key priorities were identified including:

- developing a regional commissioning framework for treatment;
- targeting those at risk and vulnerable;
- alcohol- and drug-related crime including anti-social behaviour and tackling underage drinking;
- reduced availability of illicit drugs;
- addressing community issues;
- promoting good practice in respect of alcohol- and drug-related education and prevention;
- developing harm reduction approaches; and
- workforce development

The ongoing development and implementation of the drug strategy are overseen by the NSD Steering Group and the NSD Liaison Group (see section 1.3.1).

1.2.2 Drug strategy evaluations/reviews

At present none of the current UK or devolved administration (DA) drug strategies have been formally evaluated, though there have been a number of strategy reviews published (see details below). Each review reports on progress made towards the objectives of the respective drug strategy and outlines proposed actions for future developments.

Following the publication of the *Drug Strategy Evaluation Framework* (Home Office, 2013) the Government continues to assess the effectiveness and, where possible, the value for money of the 2010 drug strategy, drawing on expert advice as appropriate. The evaluation is considering evidence for the effectiveness of the interventions which fall under the following five activity strands: (i) early interventions; (ii) media and information; (iii) treatment; (iv) non-treatment rehabilitative activity; and (v) enforcement.

Drug strategy annual review

In February 2015, the Home Office published the *Drug Strategy annual review: A balanced approach* (Home Office, 2015g). The review highlighted key achievements made in the last year towards the objectives on all three strands of the Drug Strategy 2010 and outlined priorities for the year ahead.

Main findings/key achievements

There are a number of achievements which build on the work of previous years, including a refresh of the 'Reducing Demand' strand of the strategy, the expansion of the Troubled Families programme and ongoing work to understand and tackle NPS. One of the new developments was the spring 2015 launch of "Rise Above": an online resource which aims to help build the resilience and empowerment of 11-16 year olds to enable them to make positive healthy choices (see section 4.3.1 and (UK Focal Point, 2014)).

Progress towards restricting supply included several pieces of new legislation; the *Serious Crime Act* (Her Majesty's Government, 2015b), which introduced powers for law enforcement to tackle the trade in cutting agents; the permanent control of a number of NPS and prescription medicines under the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971); and the introduction of the drug-driving offence (see section 2.2.1). Further, a guidance document was published for local authorities (LAs) to advise them of their powers to reduce the supply of NPS through "head shops" (Home Office, 2015h) (see section 2.2.3).

Under the 'Building Recovery' strand, a new condition was added to the Public Health Grant to encourage LAs to invest in the provision of high quality drug and alcohol treatment services. Similarly, a budget of £5 million was provided for the Health Premium Incentive Scheme for 2015/16, to be distributed to LAs who can show a two per cent improvement in the number of successful completions for treatment. The review also included progress made towards meeting other potential needs of those in treatment for substance misuse such as statutory guidance on social housing and improvement of training packages at Jobcentre Plus.

Recommendations/Priorities for the next year

As well as highlighting some of the key achievements, the review also presented priorities across each of the three strands for the year ahead.

There are a number of objectives which focus on reducing the demand for drugs amongst young people. This includes the promotion of evidence-based practice in schools, the continuation of funding for the Alcohol and Drug Education and Prevention Information Service (ADEPIS) (see section 4.3.1) and addressing wider aspects associated with potential substance misuse such as reducing the number of youths who are not in education, employment or training (NEET).

Other activities under the 'Reducing Demand' strand of the strategy include: increased collaboration between police, festival organisers, night time economy stakeholders and LAs; the implementation of the National Institute for Health and Care Excellence (NICE) Needle and Syringe Programme (NSP) guidance; and the continued roll-out of Liaison and Diversion schemes (see section 2.4.3).

In order to restrict the supply of illicit drugs, future work will include: a crackdown on UK-based websites in violation of the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971); an evaluation of the five new Joint Border Intelligence Units and, if successful, the roll out of further units; and increased access to centralised data on drug testing on arrest to enable the identification of local trends.

The future priorities for the 'Building Recovery' strand of the strategy cover public health, the criminal justice system, employment and housing as well as recovery and rehabilitation. Two of these goals which have now been realised are: the introduction of provisions for the wider distribution of naloxone through alterations to medical regulations, which came into effect in October 2015 (see section 2.2.1); and the introduction of new licence conditions in November 2014 for newly released prisoners to attend drug appointments in the community (see section 8.7.3).

A continued desire to reduce the harms caused by NPS is reflected by its representation in goals across all three strands of the strategy and underpinned by a wide-ranging action plan specifically looking at prevention, treatment and information sharing following recommendations made by an expert panel review published in October 2014 (Home Office, 2014a). For example, increasing training for frontline National Health Service (NHS) workers to recognise the harms of NPS and how to treat those who have used them, and developing an alert system for clinicians and outreach workers to identify and reduce potential harms. Restricting the supply of NPS is captured through the investigation of the viability of a "blanket ban" on NPS and focusing legislation on the effect a substance has on the brain rather than its chemical structure (see section 2.2.3).

Scotland

In 2011 the Drug Strategy Delivery Commission (DSDC) (see section 1.3.1) published a review of the progress made in the first three years of the drug strategy and made recommendations for the prioritisation of actions moving forward (Drug Strategy Delivery Commission, 2011). These recommendations have been progressed considerably since 2011 and the Scottish Government continues to work with partners and experts, including members of the former DSDC, to implement them. The DSDC itself was concluded in November 2014 and a new Scottish Drugs Collaborative has been developed which will include an evaluator function in its new role.

Wales

In October 2015 the Welsh Government published *Working together to reduce harm: Substance misuse strategy annual report – 2015* (Welsh Government, 2015b), reviewing progress made towards the objectives cited in their substance misuse strategy. The report highlights key developments from throughout the previous year including the publication of a number of new treatment frameworks, revised commissioning guidance and the continued investment of over £32 million from the substance misuse fund. Harm reduction and recovery remain core elements of the Wales strategy.

Priorities for the year ahead include the publication of the new delivery plan 2016-2018; commencement of work on the new substance misuse strategy for Wales 2018 to 2028; an enhanced focus on NPS including continued expansion of the Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS) project; and a number of new initiatives to address and prevent alcohol-related harm.

Northern Ireland

In July 2015 the third annual report of progress towards outcomes contained within the drug strategy was published (Department of Health Social Services and Public Safety Northern Ireland, 2015b). An assessment of the progress achieved towards short-, medium- and long-term outcomes showed that the majority of the 141 outcomes are on track for achievement within the timescale expected.¹ Fifteen (11%) of the outcomes have been completed, 99 (70%) of the outcomes are classified as being on track for achievement, and for 26 (18%) of the outcomes progress is being made but with some delay. At this stage, only one outcome, relating to research in respect of prescription drug misuse, is classified as not being on track for achievement. All outcomes are monitored and reported on annually.

A final evaluation of *NSD Phase 2* will be conducted in 2016/17 with consideration being given to a new strategy after this.

1.2.3 Commentary on drug policy

New psychoactive substances

Following the UK government NPS expert review, published in October 2014, both the Scottish Government and the National Assembly for Wales Health and Social Care Committee commissioned and published their own expert reviews (National Assembly for Wales, 2015b; Scottish Government, 2015c). Both reviews made a number of recommendations to their respective governments for tackling the harms caused by NPS within their own country. Both reviews also recommended working with the Home Office to create new legislation for a blanket ban of NPS across the entire UK. In May 2015 the newly elected Conservative government announced the proposal of a Psychoactive Substances Bill to legislate against the production, distribution, import and export of all psychoactive substances except for stated exemptions (to include alcohol, tobacco and food) (see section 2.2.3). The proposed Bill has passed through the House of Lords and is continuing to proceed through Parliament.

Carol Black Review

The Prime Minister has asked Professor Dame Carol Black to consider how best to support those suffering from long-term yet treatable conditions back into work or to remain in work. The review will focus on drug and alcohol addiction, and obesity, and will consider the holistic needs of these individuals including the effects of multiple health conditions and other barriers to work. The review will also consider the case for linking benefit entitlements to take up of appropriate treatment or support. The review is ongoing and the findings are due to be published in early 2016.

¹ These include outcomes relating to both drugs and alcohol.

1.3 Drug policy co-ordination

1.3.1 Co-ordination bodies

England

See Figure 1.1 for an accompanying summary graphic of drug treatment commissioning bodies in England.

Inter-Ministerial Group on Drugs

The Inter-Ministerial Group on Drugs, chaired by the Home Office, includes ministerial representation from across several key Government departments and oversees the delivery of the Drug Strategy.

Home Office

The Home Office is the department with lead responsibility for the co-ordination of the delivery of the Drug Strategy on behalf of the Government, and publishing annual reviews detailing the progress made towards the strategy's objectives. The DH leads on the 'Building Recovery' strand of the strategy and jointly leads on the 'Reducing Demand' strand together with the Home Office. The delivery of the strategy involves close working with a number of key departments including the MoJ, DWP, DCLG and DfE.

Advisory Council on the Misuse of Drugs

The Advisory Council on the Misuse of Drugs (ACMD) is an independent expert body responsible for advising the Home Office on drug-related matters, and was established under the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971). The ACMD is responsible for, amongst other things, making recommendations on the control of dangerous or otherwise harmful drugs, including classifications and scheduling under the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971), and carrying out in-depth inquiries which focus on emerging threats and challenges that are causing concern.

National Crime Agency

The National Crime Agency (NCA), formerly the Serious Organised Crime Agency (SOCA), became operational in October 2013. They are a non-ministerial government department, accountable to the Home Secretary, and work with the police, Border Force and international collaborators to lead the UK law enforcement's fight to cut serious and organised crime. This includes restricting the supply of drugs trafficked into the UK.

Local Authorities

In April 2013, under the *Health and Social Care Act 2012* (Her Majesty's Government, 2012b), LAs became accountable for meeting the needs of their local drug using population. LAs are now responsible for tendering and commissioning the drug and alcohol treatment services they feel will provide the most suitable support for the needs of their constituents.

The Director of Public Health (DPH) is appointed jointly by PHE and the LA, and as officer champion for health within each upper tier and unitary authority has the responsibility of delivering public health outcomes in their local area. Other LA roles which are statutory members of the Health and Wellbeing boards include: the Director for Adult Social Services; the Director for Children's Services; and an elected representative.

Health and Wellbeing Boards

Health and Wellbeing Boards (HWB) were established under the *Health and Social Care Act 2012* (Her Majesty's Government, 2012b) and assumed responsibility for providing the overall strategic direction for improving well-being in their area.

Each HWB must contain the following statutory members:

- at least one local elected representative;
- a representative of the local Healthwatch organisation;
- a representative of each local clinical commissioning group;
- the LA Director for Adult Social Services;
- the LA Director for Children's Services; and
- the Director of Public Health for the LA

Each HWB is required to produce a Joint Strategic Needs Assessment (JSNA) which outlines the current and future health and social care needs of their area and a plan to meet these needs in the Joint Health and Wellbeing Strategy (JHWS).

Healthwatch

There are 152 local Healthwatch organisations which were established under the *Health and Social Care Act 2012* (Her Majesty's Government, 2012b). They are commissioned directly by LAs and, together with the nationally-focused Healthwatch England, form the Healthwatch network. Their role is to represent the users of health and care services at the HWB, providing feedback to service providers and commissioners on how and why people use local services and their experience when doing so.

Department of Health

The DH is the government department responsible for developing the statute and policy underpinning the health and care system. It leads on the 'Building Recovery' strand and jointly manages the 'Reducing Demand' strand of the 2010 strategy with the Home Office. It is supported by key agencies such as NHS England, the Care Quality Commission (CQC) and PHE.

NHS England

Since April 2013 NHS England has been the functioning name of the NHS Commissioning Board which was established in October 2012 as an executive non-departmental public body. Even though the responsibility for the management of public health shifted away from the NHS and on to LAs in April 2013, NHS England still plays a significant role in the treatment of substance misuse. It is involved in the provision of pharmacological treatments including opioid substitution therapy (OST); the implementation of Liaison and Diversion Programmes;² and is responsible for commissioning health services within prisons, including drug and alcohol treatment services. NHS England also oversees the Clinical Commissioning Groups (CCGs) which are clinically led groups that commission local healthcare services within their geographical boundaries. This includes general practitioners, urgent and emergency care, and mental health and learning disability services. CCGs do not commission drug and alcohol treatment services directly, although it is mandatory that a representative from the local CCG sits on each HWB.

Public Health England

In April 2013 a number of functions of the National Treatment Agency were absorbed by PHE, a newly launched executive agency of DH whose role is to protect and improve the nation's health and well-being, and reduce health inequalities. PHE supports LAs to commission and deliver alcohol and drug services by providing evidence-based guidance and advice, and by collating and analysing alcohol

² Liaison and Diversion schemes are designed to identify, assess, screen and refer offenders who have mental health, learning disability, substance misuse or other vulnerabilities to an appropriate treatment or support service.
See: <https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ld-about/>

and drug treatment performance data (from the National Drug Treatment Monitoring System) for LAs. PHE uses this data to generate reports, which in turn can be fed back to LAs. PHE works with the DH which leads on the 'Building Recovery' section of the UK Drug Strategy and is also involved in the implementation of prevention activities, working towards the 'Reducing Demand' objectives.

Care Quality Commission

The CQC is an independent body charged with monitoring, inspecting and regulating health and social care services in England. Services must be registered with the CQC which then ensures that they are meeting core standards of care based on five core questions: Are they safe?; Are they effective?; Are they caring?; Are they responsive to people's needs?; and Are they well-led?

Following an inspection, the CQC will rate a service provider either Inadequate, Requires improvement, Good or Outstanding for each of the five questions. By law the organisation must clearly display these ratings in an area where service users can easily see them. The CQC will also publish a report of their findings, which will include any actions taken against the provider such as the implementation of special measures or the issuing of requirement or warning notices.

National Institute for Health and Care Excellence

NICE is an executive non-departmental public body of the DH. Their role is to develop guidance, standards and information to improve health and social care. NICE directions are used by the NHS, LAs and anyone else involved in the delivering of care. NICE products are based on the best available evidence and are developed by multi-disciplinary teams of healthcare professionals and consumers or guideline development groups with particular expertise or experience in the topic. This is to ensure that all NHS patients have the same access to treatment, and that the treatment available is cost-effective.

Ministry of Justice

Charged with protecting the public, reducing offending and overseeing courts, prisons, probation services and the secure youth estate; the MoJ are therefore involved in the hearing of criminal cases concerning drug-related offences and the rehabilitation of offenders.

National Offender Management Service

The National Offender Management Service (NOMS) is an executive agency sponsored by the Ministry of Justice. Through Her Majesty's Prison Service and the National Probation Service, NOMS is accountable for ensuring that both prison and community sentences in England and Wales are carried out.

Whilst the responsibility for prison healthcare services ultimately rests with NHS England, a National Partnership Agreement was created in October 2013 with NOMS and PHE for the co-commissioning and delivery of services in England until April 2016 (National Health Service England, Public Health England, & National Offender Management Service, 2015) (see section 8.3.2).

Department for Work and Pensions

Given the emphasis placed in the Drug Strategy on integrated working, the DWP plays an important role in ensuring that those accessing treatment are receiving the full range of benefits to which they are entitled, and supporting those recovering from addiction back into work. Universal Credit³ is a new single payment for people who are looking for work or on a low income, which brings together a range of working-age benefits, replacing the employment benefits, income support benefit, tax credits and housing benefit. It is currently being rolled out across the UK.

³ As part of Universal Credit, the Department for Work and Pensions introduced 'tailored conditionality' whereby work search and work availability requirements can be suspended for a period of up to six months in any 12 month period for claimants actively participating in structured recovery-orientated treatment. This is to give claimants the time and space to engage in treatment, and begin their recovery journey. After the end of the period of 'tailored conditionality', on-going treatment commitments are still taken into account when an individual is looking for employment. This is recognised as a critical step in enabling people with dependencies to become ready for sustainable employment.

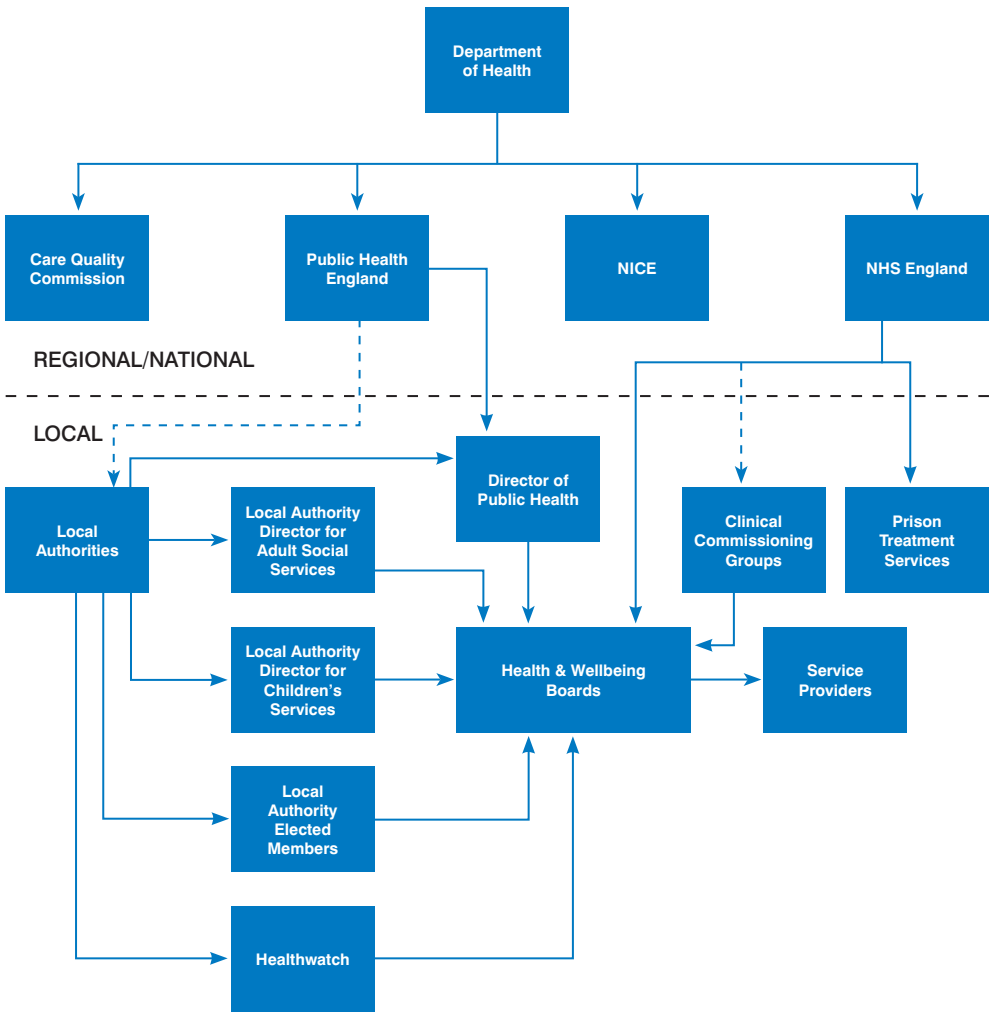
Department for Communities and Local Government

The DCLG supports local governments to help ensure that their areas are working efficiently and effectively. They publish annual reports based on fiscal data provided by LAs on their revenue expenditure and financing, including that spent under the Public Health Grant.

Department for Education

DfE is responsible for education and children's services in England. In 2013 drug education became a statutory part of the science curriculum for schools in England (see section 4.3.1).

Figure 1.1: Commissioning structure for drug treatment in England



Scotland

See Figure 1.2 for an accompanying summary structure graphic.

Scottish Government

The Scottish Government has devolved powers for policies concerning health, education, housing, social care, policing and the criminal justice system. It provides annual funding, in the region of £70 million across drugs and alcohol, to the ADPs, via NHS Boards, to enable them to implement their local delivery plans (LDPs). LDPs are guided by ministerial priorities and ADP core outcomes, informed by a robust assessment of local need and developed and delivered in line with the recognised evidence base.

Convention of Scottish Local Authorities

The Convention of Scottish Local Authorities (CoSLA) represents local governments in Scotland and was involved, along with NHS Scotland and the Scottish Government, in producing the updated guidance for ADPs.

Alcohol and Drug Partnerships

There are 30 ADPs in Scotland, and each is responsible for designing and implementing a comprehensive and evidence-based local alcohol and drugs strategy and commissioning treatment services most suitable for their local resident population. The partnerships include representatives from local NHS Boards, LAs and other key partners such as Police Scotland, the Scottish Prison Service, Housing and Social Services.

Community Planning Partnerships

The Community Planning Partnerships (CPP) hold the ADPs to account, and are involved in the generation of Single Outcome Agreements (SOA).

NHS Boards

NHS Boards develop annual LDPs which contain designated Health improvement, Efficiency and Access Treatment (HEAT) targets, including those relating to drugs and alcohol, and strategies for how they will be achieved. For 2015/16 the HEAT targets for drugs and alcohol (around reducing waiting times to treatment and delivery of Alcohol Brief Interventions (ABIs)) have evolved to become LDP Standard to support sustained performance.

Information Services Division

The Information Services Division (ISD) is part of NHS Scotland and provides health data, information and advice services which support the NHS to enable them to make informed decisions regarding health and care facilities. The Scottish Government has commissioned ISD to lead on the development of the new national combined drugs and alcohol data system, DAISy, which will eventually replace the current Scottish Drug Misuse Database (SDMD).

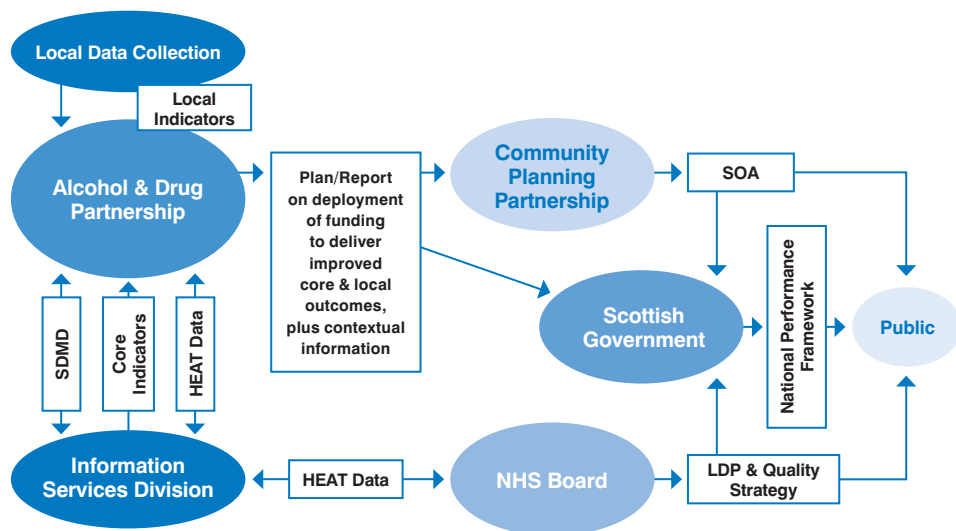
Scottish Drug Strategy Delivery Commission

The DSDC was established by the Scottish government in 2009 to independently monitor and assess the implementation and success of the national drugs strategy. This has now achieved its initial goals and was formally concluded by the then Minister for Community Safety in November 2014. Arrangements are currently being finalised for a new Scottish Drugs Collaborative structure which will replace the work of the former DSDC and lead the sector going forward. The new structure will advise, lead, and directly deliver on areas of work including: harm reduction and drug deaths; quality of standards; prevention; communities and stigma; and research.

Wales

See Figures 1.3 for an accompanying summary structure graphic.

Figure 1.2: Overview of planning and reporting arrangements for Alcohol and Drug Partnerships in Scotland



Welsh Government

The Welsh Government has devolved powers for policies concerning health, education, housing and social care.

Substance Misuse National Partnership Board

The role of the SMNPB is to guide and monitor progress and to facilitate co-ordination between the Welsh Government, statutory agencies and the third and independent sectors.

Community Safety Partnerships

Established in each of the 22 LA areas, Community Safety Partnerships (CSPs) have representatives from local stakeholders including the police, LAs, the NHS, fire and rescue services and voluntary organisations.

Area Planning Boards

Seven Area Planning Boards (APBs) were introduced in 2010 to support the planning, commissioning and performance management of substance misuse services at a regional level. The Boards include representatives from local health boards, LAs and other key partners such as police, prison, probation, housing, social services, service providers and service users.

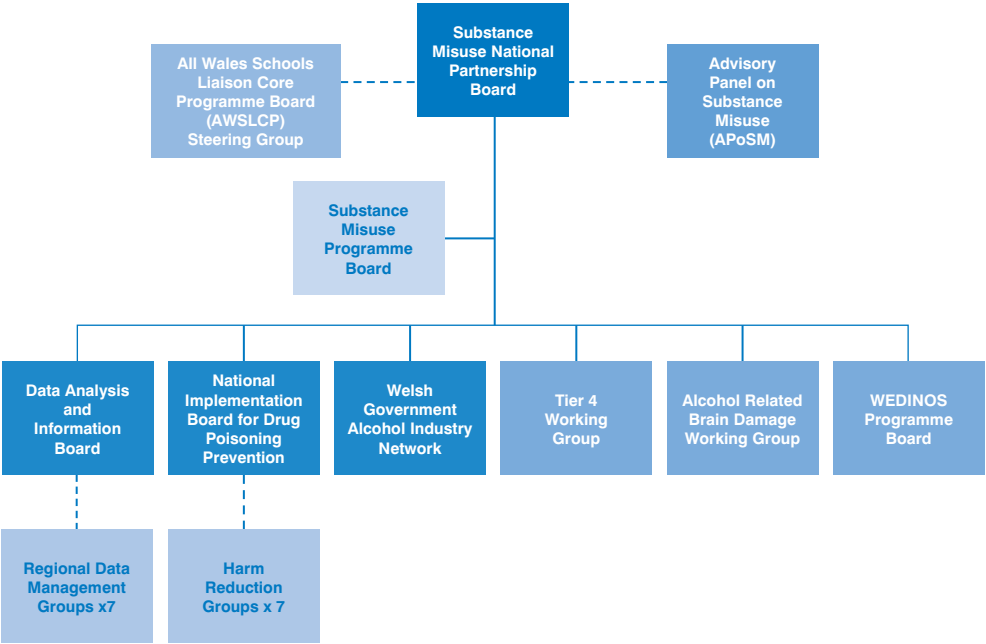
Local Health Boards

The Local Health Boards (LHBs) commission healthcare services in public sector prisons, including drug treatment services.

Advisory Panel on Substance Misuse

The Advisory Panel on Substance Misuse (APoSM) is a Welsh Government-sponsored body established under general executive powers of the Welsh Ministers. The Panel is an independent expert advisory body whose remit is to advise the Minister on measures to prevent or reduce substance misuse and the associated health and social harms.

Figure 1.3: Commissioning and reporting structure of substance misuse services in Wales



Northern Ireland

See Figure 1.4 for an accompanying summary structure graphic.

Department of Health, Social Services, and Public Safety

The Department of Health, Social Services, and Public Safety (DHSSPS) was responsible for the development and launch of the Drug Strategy in 2006 and its review and extension in 2011. DHSSPS will be responsible for the evaluation of the strategy and it is anticipated that they will retain responsibility for a successor strategy.

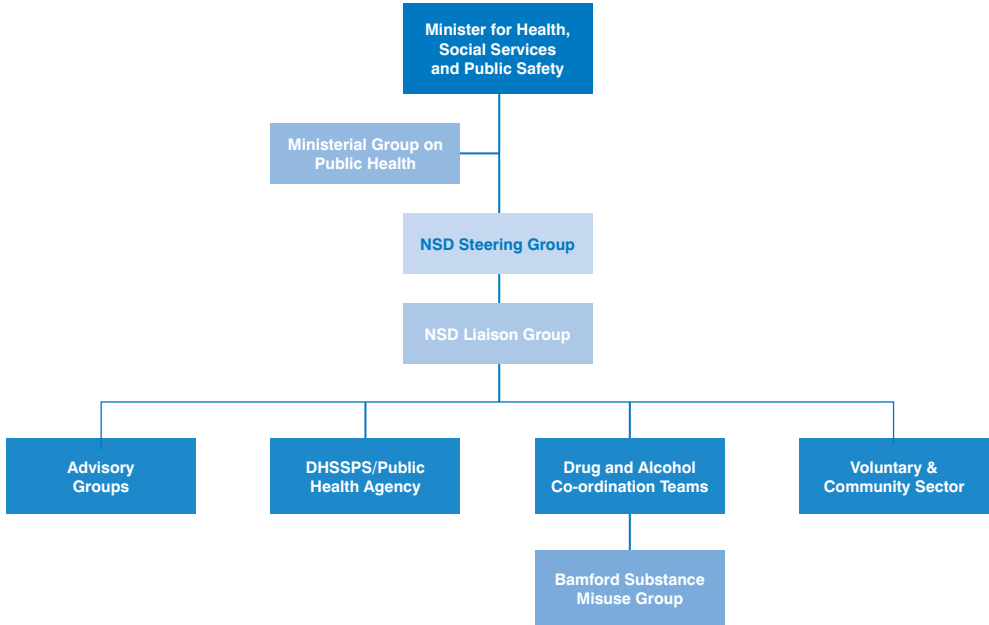
Public Health Agency

The Public Health Agency (PHA) provides expert advice and commissions a range of alcohol and drug services under the **NSD Phase 2**. They also support the work of the Drug and Alcohol Co-ordination Teams (DACTs).

New Strategic Direction Steering Group

Established in 2006, the NSD Steering group is chaired by the Chief Medical Officer. Its primary role is to oversee the ongoing policy development, delivery of the strategy and the achievement of outcomes. The Steering group includes all key government departments, including the Department of Justice and the Department for Social Development, and ensures a cross-sectoral approach to developing policy and implementing the strategy.

Figure 1.4: Commissioning and reporting structure of substance misuse services in Northern Ireland



New Strategic Direction Liaison Group

The group members include representatives from various branches of the DHSSPS including the Public Health Information and Research branch, the Health Development Policy branch and the chairs of four DHSSPS advisory groups: children, young people and families; treatment and support; alcohol advisory group; and law and criminal justice. The group monitors progress towards NSD targets and outcomes.

Drug and Alcohol Coordination Teams

DACTs generate local action plans and priorities to implement the Drug Strategy and guide the expenditure of PHA funding, including the commissioning of drug treatment services. They work closely with other local groups and partnerships, including Policing and Community Safety Partnerships.

1.4 Funding for drug treatment

England

Public Health Grant

LAs in England received a ring-fenced Public Health Grant of £2.79 billion for public health services in the 2015/16 financial year.⁴ Funding for drug and alcohol treatment is not ring-fenced within the Public Health Grant, and expenditure on services is determined by an assessment of the local populations' needs by local HWBs. LAs are required to report their annual forecasted and actual expenditure on each public health intervention making up the Grant. The categories for reporting this data include: adult drugs; adult alcohol; and young people's drug and alcohol spend.

⁴ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388172/final_PH_grant_determination_and_conditions_2015_16.pdf

Expenditure on drug misuse services for adults in England in 2013/14 was £581.1 million, with a further £74.9 million being spent on services for young people.⁵ These two elements of expenditure accounted for almost one quarter (24%) of public health spend by LAs. It is important to note that the data collection is a new exercise and there may be differences with how LAs report their public health spend.

At present there is a consultation on the proposed allocation formula which will be used to calculate funds for 2016/17.⁶ This consultation closed on 6 November 2015, and new funding allocations will be announced in due course.

Wales

The Welsh Government invests almost £50 million annually to deliver the commitments within the substance misuse strategy, *Working Together to Reduce Harm 2008-2018*, and its associated delivery plan. Alongside the £17.134 million ring-fenced funding within the Health Board budget for substance misuse services, the Substance Misuse Action Fund (SMAF) budget for 2014/15 stands at £32.047 million. Over £22 million of this funding goes directly to the seven APBs in Wales, which supports a number of projects ranging from education and prevention to treatment services.

Scotland

In 2015/16, £30.4 million was allocated to ADPs to support the delivery of improved outcomes for drugs, the same as the figure for 2014/15 and a slight increase on 2012/13 (£30.3 million). The Scottish Government is in the process of developing National Recovery Indicators to measure outcomes. These indicators will form part of a national Drug and Alcohol Information System (DAISy) planned for 2015/16.

Northern Ireland

Expenditure on alcohol and drugs services has remained broadly consistent in Northern Ireland – around £8 million per year is allocated to the implementation of the *NSD Phase 2, 2011-2016* (Department of Health Social Services and Public Safety Northern Ireland, 2011b) and a further £8 million is allocated to statutory addiction services through the mental health budget.

⁵ See: <https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2013-to-2014-individual-local-authority-data-outturn>

⁶ See: <https://www.gov.uk/government/consultations/public-health-formula-for-local-authorities-from-april-2016>

2. Legal framework and drug law offences

2.1 Introduction

The *Misuse of Drugs Act 1971* is the principal legislation in the UK for the control and supply of psychoactive substances that are considered dangerous or otherwise harmful when misused (Her Majesty's Government, 1971). Drug use is not a crime in the UK, but possession, production and dealing, as well as trafficking (including importation and exportation) are specific offences under the *Misuse of Drugs Act 1971*.⁷

The *Misuse of Drugs Act 1971* divides drugs into three classes (A, B and C) and sets maximum criminal penalties for illegal production, possession and supply in relation to each class. Drugs in Class A include cocaine, ecstasy, heroin, tryptamines (such as LSD), magic mushrooms, methadone, methylamphetamine and injectable amphetamines, as well as NBOMe⁸ compounds. Class B drugs include amphetamines, benzofuran compounds, cannabis and synthetic cannabinoids, synthetic cathinone derivatives including mephedrone, ketamine and analogue compounds including methoxetamine, and pipradrol-related compounds including desoxypipradrol (2-DPMP) and diphenylprolinol (D2PM). Class C drugs include anabolic steroids, benzodiazepines, GBL/GHB, khat, piperazines (such as BZP) and tranquilisers. The *Police Reform and Social Responsibility Act 2011* (Her Majesty's Government, 2011b) added provisions for 12-month Temporary Class Drug Orders (TCDOs) enabling law enforcement activity against those trafficking and supplying new psychoactive substances (NPS) (see section 2.2.3). There are no possession offences associated with TCDOs.

Most drugs controlled under the Act are also placed in one of five schedules to the *Misuse of Drugs Regulations 2001* based on an assessment of their medicinal or therapeutic usefulness, the need for legitimate access and their potential harms when misused (Her Majesty's Government, 2001b).⁹ The schedules determine the circumstances in which controlled substances can be lawfully manufactured, possessed and distributed. Schedule I is for substances deemed to have no therapeutic value so cannot be prescribed. Research can be conducted on these substances but this requires a license to be obtained from the Home Office. At the other end, Schedule V drugs can be legally supplied and possessed without prescription.

Under the *Misuse of Drugs Act 1971*, police have special powers to stop, detain and search people on 'reasonable suspicion' that they are in possession of a controlled drug. Police may also enter and search premises with a warrant if there are reasonable grounds to suspect an offence against the Act has been committed. A prison sentence is the most common outcome when found guilty at court of import/export and trafficking offences but a fine, community sentence or conditional discharge are the most common disposals for possession offences. The range of possible penalties is covered in section 2.3.2.

The *Drugs Act 2005* amended the *Police and Criminal Evidence Act 1984*, introducing mandatory drug testing of detainees following arrest in certain circumstances (Her Majesty's Government, 1984). The Act also introduced a new offence of failing to attend a Required Assessment with a drug worker for those testing positive (see section 2.4.2). These amendments provided a legally enforceable lever through which to identify drug using offenders on arrest and to engage them with treatment.

⁷ **Possession:** In the UK it is unlawful to possess any quantity of a controlled drug, unless the individual is in possession of an authorisation in the form of a licence (for example a prescription), or the person can prove that they were unaware that the substance was a controlled drug.

Supply and possession with the intent of supply: Supply defined as the simple act of passing a controlled drug from one person to another. According to the law, it is irrelevant if the act is done for profit or not. The financial gain has influences only on the sentence given.

Production: In the UK it is illegal to produce any controlled drug, unless the individual is in possession of an authorisation in the form of a licence. Production is defined as 'manufacturing, cultivating or production by any other method'.

⁸ NBOMe refers to a family of hallucinogenic drugs.

⁹ See: <https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence/supporting-pages/classifying-and-controlling-drugs>.

To protect young people, the *Drugs Act 2005* sets out aggravating factors which must be taken into account by courts when considering the seriousness of an offence of supply of a controlled drug by a person aged 18 or over. These include when the offence was committed in the vicinity of school premises at a relevant time and when the offender engaged someone under the age of 18 as a courier.

2.2 Legal Framework

2.2.1 Recent changes to drug misuse legislation

Drug driving legislation

England and Wales

The *Crime and Courts Act 2013* (Her Majesty's Government, 2013a) makes it an offence to drive or be in charge of a motor vehicle with a blood concentration of specified controlled drugs above certain limits. In 2014, following an expert panel report (which offered suggestions about the best course of action on specified drugs and limits for each drug under the legislation) (UK Focal Point, 2012; Wolff et al., 2013) and a public consultation, the Government announced that they accepted the panel's recommendations on the blood concentration limits suggested for eight illegal drugs and eight drugs mostly associated with medical uses. The new regulations came into force in England and Wales in March with the setting of blood concentration limits for 16 substances specified in *The Drug Driving (Specified Limits) (England and Wales) Regulations 2014* (Her Majesty's Government, 2014). There is a 'zero tolerance' approach to eight drugs most associated with illegal use (i.e. at a level designed only to exclude accidental exposure) and a road safety risk-based approach to eight drugs most associated with medicinal use.

Table 2.1: Threshold limits for blood drug concentrations

'ILLEGAL' DRUGS ('ACCIDENTAL EXPOSURE' – ZERO TOLERANCE APPROACH)	THRESHOLD LIMIT IN BLOOD FOR 'ILLEGAL' DRUGS	'MEDICINAL' DRUGS (RISK BASED APPROACH)	THRESHOLD LIMIT IN BLOOD FOR 'MEDICINAL' DRUGS
Benzoylcegonine (cocaine metabolite)	50µg/L	Amphetamine	250µg/L
Cocaine	10µg/L	Clonazepam	50µg/L
Delta-9-tetrahydrocannabinol (cannabis)	2µg/L	Diazepam	550µg/L
Ketamine	20µg/L	Flunitrazepam	300µg/L
LSD	1µg/L	Lorazepam	100µg/L
Methylamphetamine	10µg/L	Methadone	500µg/L
MDMA	10µg/L	Morphine	80µg/L
6-monoacetylmorphine (heroin)	5µg/L	Oxazepam	300µg/L

Source: (Her Majesty's Government, 2014)

Scotland

Drug driving is reserved to the UK Government, but two aspects of the new offence: the power to specify the controlled drugs that will trigger the new offence; and the applicable limits that will trigger the new offence, are devolved to Scottish Ministers.

The UK Government launched a consultation paper on the new drug driving offence on 9 July 2013 and, at the request of the Scottish Government, this consultation covered Scotland as well. An analysis report on the consultation responses in relation to Scotland were published on 3 July 2015. The views offered in the consultation will help to inform decisions on whether a new drug driving offence for Scotland should be introduced (Scottish Government, 2015b).

Northern Ireland

Legislation in relation to drug driving is devolved to Northern Ireland and the work undertaken by the UK Government will inform any final policy proposals for Northern Ireland.

Stop and search

In March a revised version of the *Police and Criminal Evidence Act, Code A* (Home Office, 2015d), came into force. It included amendments to the meaning of 'reasonable grounds for suspicion'. It stipulates that an officer must have an objective basis for suspicion (fact, information and/or intelligence) and that personal factors can never support reasonable grounds for suspicion. It also emphasises that the misuse of stop and search powers will lead to formal performance or disciplinary proceedings.

A change to the Misuse of Drugs Act 1971: control of MT-45 and 4,4'-DMAR

In February 2015 Parliament approved the recommendation of the Advisory Council on the Misuse of Drugs (ACMD) to control NPS known as MT-45 (a synthetic opioid) and 4,4'-DMAR (a chemical stimulant) due to their potential to cause serious harm including deaths. Amendments to the *Misuse of Drugs Act 1971* and its subordinate legislation to permanently control such compounds as Class A came into force on 11 March 2015 (Home Office, 2015c).

A change to the Misuse of Drugs Act 1971: control of AH-7921, LSD-related compounds, tryptamines, and rescheduling of GHB

In January 2015 the Home Office controlled the following compounds (or class of compound) as Class A drugs under the *Misuse of Drugs Act 1971 (Amendment) (No. 2) Order 2014 (001/2015)*:

- the synthetic opioid AH-7921;
- the LSD-related compounds commonly known as ALD-52, AL-LAD, ETH-LAD, PRO-LAD and LSZ; and
- the compounds captured by the extended definition of tryptamines, including compounds commonly known as AMT and 5-MeO-DALT

These changes came into effect on 7 January 2015 (Home Office, 2015b).

Availability of naloxone

In October 2015 legislative changes came into force to increase the availability of naloxone. These changes made naloxone exempt from prescription-only medicine requirements when it is supplied by a drug service commissioned by a local authority (LA) or the National Health Service (NHS). This will make naloxone easier to access not only by individuals who are using or have previously used opioids and are at potential risk of overdose, but also by their carers, a family member or friend, and/or a named individual in a hostel or other facility where drug users gather.

Serious Crime Act 2015

The *Serious Crime Act 2015* (Her Majesty's Government, 2015b), enacted in March 2015, gives effect to a number of legislative proposals suggested by the *Serious and organised crime strategy* (Her Majesty's Government, 2013b). It builds on current criminal and civil law to ensure that law enforcement agencies have the powers to continue to disrupt the activities and bring to justice serious and organised criminals. It introduced powers for law enforcement officers to tackle the trade in cutting agents, allowing them to enter premises, with a warrant, where there are reasonable grounds to suspect chemicals are being used for unlawful conduct, as well as to seize, detain and destroy certain substances. The Act strengthened the *Proceeds of Crime Act 2002* (Her Majesty's Government, 2002) enabling assets held by defendants and others to be frozen and recovered, and traffickers prosecuted more quickly. The *Serious Crime Act 2015*

also made it an offence to throw any article or substance into a prison. Those found guilty could face up to 12 months in jail or a fine or both for a summary conviction, or up to two years in jail or a fine or both for an indicted conviction.

2.2.2 Advisory Council on the Misuse of Drugs (ACMD)

Ketamine: Rescheduling and Patient Group Directions

In June 2014, the Government accepted the recommendation of the ACMD and reclassified ketamine as Class B. They also held a public consultation on the impact of listing ketamine in Schedule II of the 2001 Regulations (UK Focal Point, 2012). In February 2015, the ACMD informed the Government that if ketamine was listed in Schedule II, as they recommended, this would place it outside the remit of Patient Group Directions (PGD). Consequently, certain healthcare providers would not be able to supply or offer to supply the drug for immediate treatment to patients, when not under the direct supervision of a medical practitioner.¹⁰ Therefore, the ACMD recommended that specific exceptions should be put in place to ensure that ketamine continues to be available under PGDs when it is rescheduled. In her reply the then Minister of State informed the ACMD that in light of the consultation outcomes¹¹ and their further recommendation, she had approved the rescheduling of ketamine from Part 1 of Schedule IV to Schedule II of the 2001 Regulations, including the legislative changes needed to ensure its continued use under PGDs. On 30 November 2015, ketamine became a Schedule II controlled drug under the *Misuse of Drugs Regulations 2001*.

Misuse of Drugs (Amendment)(No.2)(England, Wales and Scotland) Regulation 2015

The ACMD has approved¹² the Home Office's suggestion to review specific provisions under the *Misuse of Drugs Regulations 2001* (Her Majesty's Government, 2001b), with the aim of increasing the flexibility and access to controlled drugs by removing unnecessary barriers whilst implementing better monitoring of the ordering of controlled drugs stocks by healthcare professionals within the community. The Government¹³ acknowledged the ACMD's support for these changes and they were implemented on 1 June 2015 (except for changes relating to ketamine and mandatory requisition forms, which came into force on 30 November).

Electronic Prescribing Service (EPS) for Schedules II and III Controlled Drugs

In July 2014 the Government launched a consultation on the joint proposal by the Department of Health and Home Office to enable the Electronic Prescribing Service (EPS) for Schedules II and III controlled drugs for NHS and private prescribers. As a result of a positive response to the consultation¹⁴ and support from the ACMD (which also recommended that the implementation of such changes should be contingent on compliance with the 'Advanced Electronic Signature' standard and other security standards required of NHS prescribers), the Government has made the necessary legislative amendments to enable the electronic prescribing of Schedules II and III controlled drugs, and the legislation came into force in July 2015.

¹⁰ Subject to some specific exceptions, the use of controlled drugs under PGDs is limited to drugs listed in Schedule IV and V to the 2001 Regulations.

¹¹ A summary of the consultation responses included in the letter to the ACMD reported that the vast majority of the responses to the consultation supported the rescheduling of ketamine to Schedule II of the Misuse of Drugs Regulations 2001, but they also agreed that such rescheduling should not be a burden to the veterinary practices and healthcare organisations that already treat ketamine as a Schedule II drug. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417601/Ketamine_Consultation_-_Summary_of_Responses.pdf

¹² See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416670/25_03_2015_ACMD_Advice_-_Proposals_to_review_amend_specific_provisions_under_MDR_2001.pdf

¹³ See : https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418399/2015-03-25-LF-LI-Misuse_of_Drugs_Regulations.pdf

¹⁴ See; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/415885/consultation_response.pdf

New Temporary Class Drug Order for compounds related to methylphenidate

In April 2015, the Government accepted the ACMD's recommendation to put under a TCDO five compounds related to methylphenidate.^{15,16} Consequently, the substances ethylphenidate, 3,4-dichloromethylphenidate ('3,4-DCMP'), methylphenidate ('HDMP-28'), isopropylphenidate ('IPP' or 'IPPD') and propylphenidate became subject to a TCDO pursuant to section 2A of the *Misuse of Drugs Act 1971*. In June 2015 a further TCDO was introduced to cover 4-methylmethylphenidate ('4-Me-TMP') and ethylphenidate ('HDEP-28') alongside the original five substances.¹⁷

2.2.3 Legislation designed to control new psychoactive substances

Temporary Class Drug Order

Since November 2011, with the amendment to the *Misuse of Drugs Act 1971* made by the Police Reform and Social Responsibility Act 2011 (Her Majesty's Government, 2011b), the Home Secretary has had the power to make a TCDO where, following consultation with or a recommendation from the ACMD, there is sufficient concern about the potential harms of a NPS. The importation, exportation, production and supply of a drug which is subject to a TCDO are unlawful. While the personal possession of a temporary class drug is not an offence, the police have the power to seize and destroy any drug suspected of being subject to a TCDO. The order can last for a maximum of 12 months.

The Forensic Early Warning System (FEWS) was set up in January 2011 to forensically identify NPS in a prompt manner, in order to assist the ACMD and the Government to tackle the threat posed by emerging substances (UK Focal Point, 2012). It forms part of the Government's wider action on NPS, as set out in the NPS Action Plan (Home Office, 2012). FEWS collected samples from the internet and head shops, music festivals, the police and border control to identify which NPS are present in the UK or being offered for sale in the UK market.

New Psychoactive Substances Bill

Following a six-month review of the UK's response to NPS undertaken by an independent expert panel, 31 recommendations on new and bespoke measures ranging from legislation to prevention, education, information sharing, treatment and interventions were put to the Government (Home Office, 2014a). Among the recommendations was a proposal for a blanket ban on supply of NPS, similar to that introduced in Ireland in 2010. The prospective ban has been welcomed in a report on NPS by an Expert Review Group established by the Scottish Government (Scottish Government, 2015b), as well as in a report by the National Assembly for Wales' Health and Social Care Committee (National Assembly for Wales, 2015b). In May 2015 the newly elected majority Conservative Government announced the proposal of a Psychoactive Substances Bill to legislate against the supply, production, distribution, import and export of all psychoactive substances except for stated exemptions (to include alcohol, tobacco and food). The Bill will proceed through Parliament over the autumn with anticipated Royal Assent by the end of 2015 and commencement in spring 2016.

New psychoactive substances in prison

In January 2015 the *Criminal Justice and Courts Act* (Her Majesty's Government, 2015a) provided additional powers to prison governors to test for non-controlled drugs, such as NPS, in mandatory drug testing and to impose stiffer penalties on those suspected of being involved in smuggling NPS into prisons. New sanctions include 'closed visits' (no contact with partners or children), extended or further sentences, solitary confinement, forfeiture of prison wages and/or privileges and being moved to a higher security prison.

¹⁵ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/420983/TCDO_methylphenidate_NPS.pdf

¹⁶ Methylphenidate in the UK, it is controlled as a Class B material and as a Schedule II substance under the Misuse of Drugs Regulations 1971

¹⁷ See: <https://www.gov.uk/government/news/two-new-legal-highs-to-be-banned-under-temporary-order>

Local Government powers to tackle new psychoactive substances

England

In January 2015 a councillors' guide was published by the Local Government Association (LGA) which aimed to provide LAs with information on how they can protect their community from the harms of NPS use under the existing legal framework. The guidance contains an introduction to NPS, suggestions on how they can raise awareness of the harm of NPS use and information on what LAs can do to tackle sales of NPS in their areas (Local Government Association, 2015). Guidance to LAs was also published by the Home Office with the aim of highlighting the main legislative measure they have to tackle 'head shops' that are selling NPS (Home Office, 2015h).

Scotland

Following a recommendation made by the Scottish Government NPS Expert Review Group (26 February 2015), Scottish Ministers wrote to Scottish licensing authorities to request conditions and restrictions be added to public entertainment licences to ban the sale of NPS at music festivals and events.

Local Initiatives targeting new psychoactive substances

England

Lincoln 'legal high' ban

Following a public consultation on banning the consumption of intoxicating substances¹⁸ in public (where 97% of respondents supported the ban) the City of Lincoln Councillors, in February 2015, voted to introduce a Public Space Protection Order (PSPO). This allowed the council to place an order to ban persistent activities that are having a detrimental effect on the quality of life for people in their community. The ban came into action in April 2015. This new power was introduced as a replacement of an existing Designated Public Place Orders (DPPO), which allowed only the prevention of alcohol consumption in certain areas under specific circumstances. Since the Lincoln ban, other LAs have introduced similar measures.

Northern Ireland

Belfast City Council Injunction and Prosecution

Following action under **General Product Safety Regulations (GPSR) 2005**,¹⁹ Belfast City Council (BCC) was granted forfeiture orders at Belfast Magistrates Court in respect of NPS products seized from a number of shops that refused to voluntarily surrender their stock. The Council, working with the Attorney General for Northern Ireland, sought an injunction to try to stop the sale and distribution of NPS in Northern Ireland. This was granted by the High Court against a number of defendants on two grounds. The first was to stop the further commission of offences under the GPSR, and the second was on the basis that their sale in the locality of the shops constituted a public nuisance. In tandem with the injunctive proceedings, BCC also took a prosecution against the defendants for breaching the GPSR as the NPS products did not meet the safety standards set out in the Regulations. All the defendants pleaded guilty. The offences were as follows: Regulation 8(1)a — supplying a product which they knew or should have presumed to be dangerous; Regulation 8(1)b(ii) — failure to keep documentation necessary for tracing the origin of the product; and Regulation 8(b)(iii) — failure to produce documentation necessary for tracing the origin of the product and failure to co-operate with action taken by BCC. Following the joint prosecution, a full injunction against the defendants was granted and this has had a significant impact on the retail of NPS in Belfast.

¹⁸ Intoxicating substances are defined as 'Substances with the capacity to stimulate or depress the central nervous system' and they include alcohol and so called 'legal highs'

¹⁹ See: http://www.legislation.gov.uk/uksi/2005/1803/pdfs/uksi_20051803_en.pdf

2.3 Drug law offences

2.3.1 Types of offences and range of penalties

There are a number of activities related to controlled drugs that are considered offences under the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971). These are: possession; supply (dealing); possession with intent of supply; production; importation and exportation (trafficking); and offences related to the use of a controlled drug on premises. The severity of the penalty applied is dependent on the 'class' of the drug involved and the individual circumstances of the case. For each type of offence, the court has to consider the size of the operation/quantity of drugs involved, the individual's role in the crime, and any aggravating or mitigating factors in order to impose an appropriate penalty in accordance with the definitive guidelines (Sentencing Council, 2009, 2012).

Table 2.2: summarises the maximum penalties according to the offence and the type or 'class' of the drug involved.

Table 2.2: Maximum penalties for drug possession

CLASS	DRUG	POSSESSION	SUPPLY AND PRODUCTION
A	Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine	Up to seven years in prison, an unlimited fine or both	Up to life in prison, an unlimited fine or both
B	Amphetamines, barbiturates, cannabis, codeine, ketamine, methylphenidate, synthetic cannabinoids, synthetic cathinones	Up to five years in prison, an unlimited fine or both	Up to 14 years in prison, an unlimited fine or both
C	Anabolic steroids, benzodiazepines (e.g. diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (e.g. BZP), khat	Up to two years in prison, an unlimited fine or both (except anabolic steroids – it is not an offence to possess them for personal use)	Up to 14 years in prison, an unlimited fine or both
TCDO*	(Currently) Ethylphenidate, 3,4-dichloromethylphenidate ('3,4-DCMP'), methylphenidate ('HMP-28'), isopropylphenidate ('IPP' or 'IPPD'), 4-methylmethylphenidate ('4-Me-TMP'), ethylphenidate ('HDEP-28'), propylphenidate, and their simple derivatives	None, but police can take away a suspected temporary class drug	Up to 14 years in prison, an unlimited fine or both

*The government can ban new drugs for one year under a "temporary banning order" while they decide how the drugs should be classified.

Source: <https://www.gov.uk/penalties-drug-possession-dealing>

First and second simple possession offences for cannabis and khat (for personal use) are dealt with using out-of-court disposals in England and Wales. In the case of first offences, this takes the form of a spoken 'cannabis warning' or 'khat warning' respectively. Second offences generally incur a penalty notice for disorder of £80 under the *Criminal Justice and Police Act 2001* and the *Schedule to the Penalties for Disorderly Behaviour (Amount of Penalty) Order 2002* (Her Majesty's Government, 2001a).

2.3.2 Data on drug law offences

Data on drug law offences are available at various points in the criminal justice system:

- Recorded crime data count the number of drug offences brought to the attention of police and represent the widest measure of drug offences available in the UK. However, at present the individual drug involved is not recorded (except for cannabis possession offences).

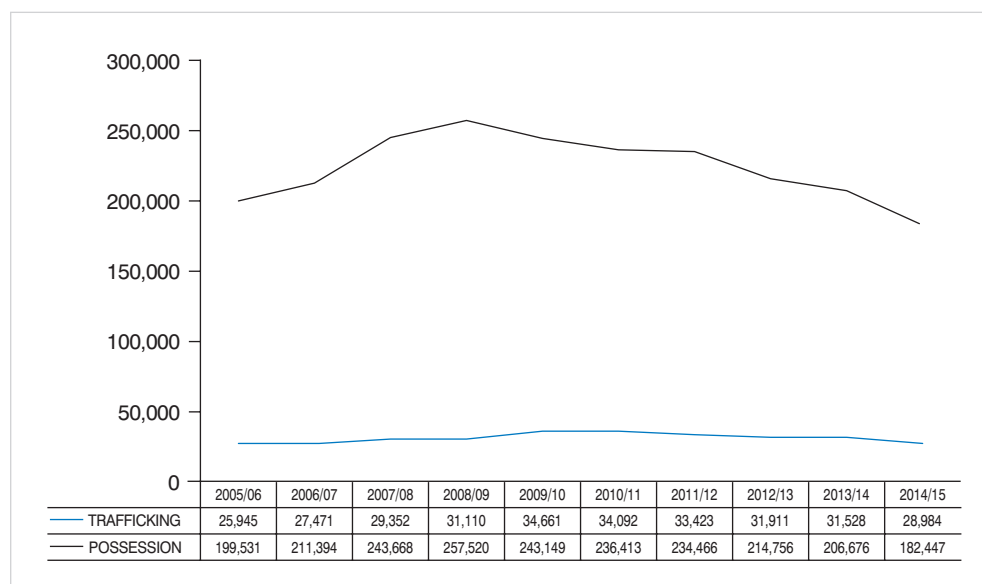
- Arrests data record the number of persons who are arrested for a drug offence and represent a smaller proportion of drug offences, since some penalties such as formal warnings for cannabis do not constitute an arrest. These data are not available by drug or by offence type.
- Finally, cautions and convictions data record the number of offences where an individual is found guilty at court or cautioned for a drug offence.

Data from each level of the criminal justice system cannot be compared for a number of reasons including: time lag between offence and conviction; the basis on which the data are provided (offender or offence); counting rules; and year of data (calendar or financial year). It should be noted that changes in police activities and priorities will impact on the recording of drug offences and, as such, trends may not be entirely reflective of underlying levels of drug offending. Further information on the recording of drug offence data are contained in a selected issue chapter on sentencing statistics in the *UK Focal Point Report 2008* (UK Focal Point, 2008).

Recorded crime: drug offences

There has been a downward trend in recorded drug offences in the UK in recent years; however, trends differ between the administrations. Northern Ireland has seen a fairly steady increase in both trafficking and possession offences recorded over the last decade with around twice the number of each category reported in 2014/15 as were in 2006/07 (although slightly fewer trafficking offences were reported in 2014/15 than in the previous year).²⁰ While the overall number of recorded drug offences in Scotland has fallen over the last five years, this is due to a substantial fall in trafficking offences, while possession offences have risen (Scottish Government, 2015d). Due to size, the trends for England and Wales (which are reported together) are broadly similar to the overall UK picture, with both possession and trafficking offences having fallen in recent years (Home Office, 2015e).

Figure 2.1: Trends in recorded possession and trafficking offences in the UK: 2004/05 to 2014/15



Source: (Home Office, 2015e; Scottish Government, 2015d) Police Service of Northern Ireland²¹

²⁰ See: http://www.psnri.police.uk/index/updates/updates_statistics/updates_crime_statistics/updates_crime_statistics_archive.htm

²¹ See: http://www.psnri.police.uk/index/updates/updates_statistics/updates_crime_statistics/updates_crime_statistics_archive.htm

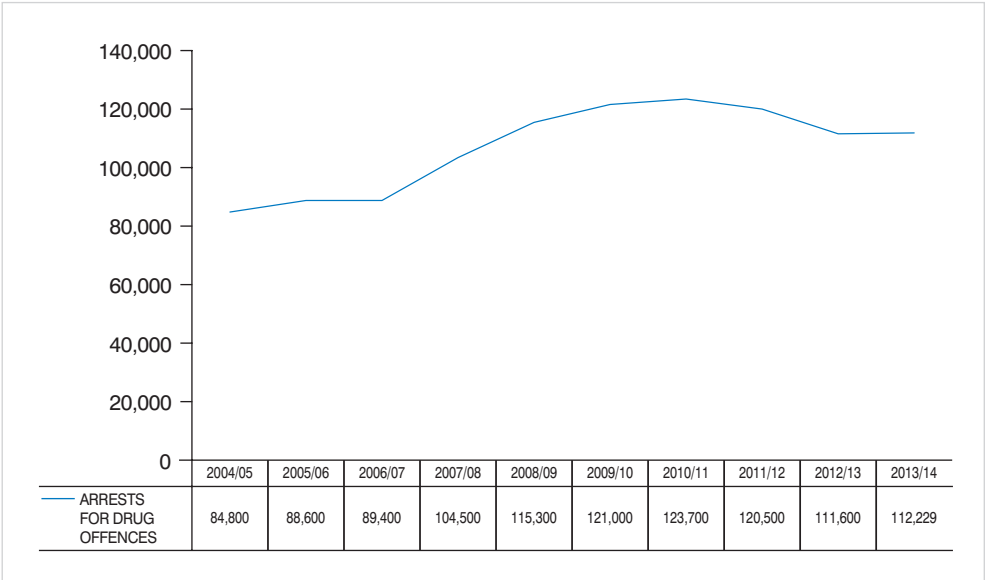
Arrests for drug offences

Having risen between 2006/07 and 2010/11, arrests for drug offences in England and Wales have dropped in recent years but remain more numerous than before the rise.

Convictions and cautions for drug offences

There were 139,759 drug offences where the person was found guilty at court or cautioned in the UK during 2013 (Table 2.3), a three per cent reduction on the previous year ($n=144,434$). Having fallen sharply from 2010 to 2012 (a total decrease of 31%), convictions relating to heroin have plateaued since 2012 (one per cent decrease). The decrease of heroin convictions seen between 2010 and 2012 may reflect the reduced availability of heroin during this period; a pattern seen in other indicators. Having steadily risen between 2007 and 2011, the number of cannabis convictions fell by four per cent in 2013 but is still far higher than in 2007 (+30%). Cocaine powder convictions continued to fall in 2013 (two per cent), if less sharply than in previous years. The number of convictions for other drugs remained fairly stable, apart from ecstasy offences which continued to increase by nine per cent since 2012, a total rise of 83% since 2010.

Figure 2.2: Trends in arrests for drug offences in England and Wales: 2004/05 to 2013/14



Source: (Home Office, 2015)

Out of court disposals and sentencing of drug offenders

In 2014, there were 143,120 proven drug law offences²² in England and Wales, representing a 17% decrease from the previous year (Ministry of Justice, 2013a). The majority of drug offences were dealt with outside of a court setting (64%). Of the drug offences settled outside of court, over half were in the form of a cannabis warning (55%), followed by cautions (32%), with penalty notices for disorder accounting for 12%.

²² Defendants who have been proven to have committed an offence (includes convictions, cautions, cannabis warnings and Penalty Notices for Disorder).

Table 2.3: Drug offences where the offender was found guilty or issued a caution in the United Kingdom

DRUG	2004*	2005	2006	2007	2008	2009	2010	2011	2012	2013
Amphetamines	6,249	6,864	7,422	7,478	7,822	7,096	7,487	7,831	6,488	6,338
Cannabis	82,845	54,813	55,984	55,563	63,103	66,598	75,284	80,023	75,116	71,980
Cocaine powder	9,382	12,028	15,470	19,216	22,874	22,529	20,034	20,102	18,723	18,381
Crack cocaine	2,450	3,734	4,076	4,613	5,895	4,241	3,679	3,791	3,845	3,815
Ecstasy	6,209	6,337	6,233	7,189	5,107	3,608	1,812	2,512	3,045	3,323
Heroin	12,412	15,629	15,741	16,557	17,926	16,354	16,648	12,816	11,438	11,326
LSD	90	183	172	165	156	106	69	88	50	63
Total†	122,459	118,706	124,344	135,655	149,203	147,013	152,451	154,212	144,434	139,759

*Data since 2005 are on an all offence basis; data for the years before 2005 are based on principal drug offence.

†The total refers to the total number of reports against drug legislation. Not all drug offences data are reported by drug type; therefore, the total reported in the table includes other type of offences such as those involving premises and miscellaneous drug offences.

Source: ST11

Of the 51,297 individuals sentenced at court for drug offences in England and Wales during 2014, 17% were given immediate custody (Ministry of Justice, 2015a), a similar proportion to previous years. The most common sentence was a fine, meted out in 38% of cases. The vast majority of those convicted of import/export offences received immediate custody (82%) (Table 2.4), with an average custodial sentence length of 81.9 months for Class A importation offences (Table 2.7). The distribution of sentencing outcomes for drug law offences was similar in Northern Ireland in 2014 although with greater use of conditional discharges and a smaller proportion of offenders given fines.

Table 2.4: Number and percentage of offenders receiving each disposal at court for drug offence type in England and Wales, 2014

	IMMEDIATE CUSTODY		SUSPENDED SENTENCE		COMMUNITY SENTENCES		FINE		OTHER		TOTAL SENTENCED	
	n	%	n	%	n	%	n	%	n	%	n	%
Import/export	375	82.1	49	10.7	18	3.9	8	1.8	7	1.5	457	100
Trafficking*	7,143	43.3	4,754	28.8	2,889	17.5	969	5.9	744	4.5	16,499	100
Possession	1,184	3.5	602	1.8	4,029	12.0	18,519	54.9	9,371	27.8	33,705	100
Other	54	8.5	120	18.9	218	34.3	136	21.4	108	17.0	636	100
Total	8,756	17.0	5,525	10.8	7,154	13.9	19,632	38.3	10,230	19.9	51,297	100

*Includes production, supply and possession with intent to supply.

Source: (Ministry of Justice, 2015a)

2.4 Drug interventions in the criminal justice system

Rehabilitative and treatment opportunities are made available to those who need them at all stages of the criminal justice system (police station, court, community sentence or custody), either on a voluntary basis, or as part of a court mandated sentence or post-release licence.

2.4.1 Drug Rehabilitation Requirement in England and Wales

Under Section 209 of the *Criminal Justice Act 2003 (Her Majesty's Government, 2003)*, a Drug Rehabilitation Requirement (DRR), comprising structured treatment and regular drug testing, was made available to courts as a sentencing option for offences from April 2005. A DRR can be made as part of a Community Order (CO) or a Suspended Sentence Order (SSO). These provisions aim to present local providers with flexibility to tailor requirements to individual needs, changing patterns of substance misuse and moving towards a recovery-focused approach to treatment. In England, separate provision is not generally commissioned to support DRRs; rather the treatment element of DRRs is provided from drug treatment services commissioned for the mainstream local treatment population.

The supervision on licence of low to medium risk offenders is now managed by Community Rehabilitation Companies as part of the changes brought in by *Transforming Rehabilitation: A strategy for reform* (Ministry of Justice, 2013b), with high risk offenders being supervised by the new the National Probation Service (see section 8.3.1). In Wales, the Director of National Offender Management Service (NOMS) Wales is responsible for the planning and commissioning of drug treatment services for offenders on DRRs.

2.4.2 The Former Drug Interventions Programme in England and Wales

The Drug Interventions Programme (DIP), established in 2003, was the primary method of engaging drug misusing offenders with drug treatment services in England and Wales between 2003 and 2013. Under the national DIP programme, Criminal Justice Intervention Teams (CJITs) provided case management, low threshold interventions and referrals to structured treatment. Mandatory test on arrest was implemented in 2006 for specified 'trigger offences' (i.e. those most associated with drug use: shoplifting, robbery, theft) in areas designated as being 'DIP intensive'. DIP ceased to be a national programme from April 2013. The funding from the Home Office and the Department of Health that was previously ring-fenced for the programme has been subsumed into the Police Main Grant and the Public Health Grant, with the decision as to whether to continue funding such interventions taken locally according to an assessment of local need. The majority of LAs continue to report CJIT activity to Public Health England (PHE) and around 28 police forces still run a drug intervention initiative based on drug testing on arrest, suggesting that the provision of such services has largely survived the transition to a locally led commissioning structure (personal communication — Home Office).

2.4.3 Liaison and Diversions

The Liaison and Diversion (L&D) programme was created in 2010 in response to the findings of the Bradley Report (Department of Health, 2009). L&D schemes are designed to identify, assess, screen and refer offenders who have mental health, learning disability, substance misuse or other vulnerabilities to an appropriate treatment or support service.

Key elements of the operating model are:

- an all-age service;
- meets a wide range of vulnerabilities;
- available throughout varying points of the justice pathway;
- provides a 24/7 service;

- there is a core team who are supported by an extended team and engagement workers liaising between the two; and
- has three distinct phases which are case identification, secondary screening/triage and assessment including specialist assessment

Ten trial schemes were implemented from 1 April 2014 with a further 15 schemes instigated from 1 April 2015, taking coverage up to 50% of England. It is anticipated that full coverage will occur from 2017.

2.4.4 Out-of-Court Disposal Pilots

The Government is piloting (in three police forces) a new out-of-court disposal framework for cannabis and khat possession offences, which seeks to direct users into appropriate treatment to help modify drug misuse behaviour.

A community resolution replaces the existing initial warning for cannabis and khat possession offences and a conditional caution replaces the old Penalty Notice for Disorder (PND). The aim is for individuals to be referred to drug treatment workers who have a range of interventions available to them. Interventions at the community resolution stage are voluntary but the interventions are enforced as part of the conditional caution, with the individual subject to prosecution if they do not comply.

The pilots also provide an opportunity for more effective use of disposals with a greater focus on rehabilitation and reduction of reoffending — they provide a wide scope to impose 'positive conditions' on a disposal. They also provide an opportunity to help to ensure that those who would benefit from more structured treatment would be referred on.

Prison drug treatment and reintegration of drug users after release from prison is covered in the prison chapter (see section 8.5.2).

Scotland

In Scotland, there are a number of interventions at different levels of the criminal justice system, including diversion from prosecution to drug treatment/education, community payback orders with a drug treatment requirement and Drug Treatment and Testing Orders (DTTOs) for particularly high tariff offenders who are entrenched in their drug use, as well as services for prisoners post-release, including Throughcare Addiction Services. DTTOs provide offenders with access to treatment services, which they are required to comply with, combined with regular progress reviews from the Court. A less intensive version (DTTO II) has been developed for lower tariff offenders and rolled out on a pilot basis in Edinburgh and the Lothians from June 2008, and currently accounts for about a quarter of the DTTOs in these areas.

3. Prevalence, availability and relative importance of different drugs

3.1 Introduction

The principal sources of information on the prevalence of drug use in the United Kingdom (UK) are General Population Surveys (GPS). The *Crime Survey for England and Wales* (CSEW) provides estimates of the prevalence of drug use in the general population in England and Wales. Scotland and Northern Ireland also undertake similar surveys. In addition to these household surveys conducted on adults, there are also surveys targeted at school children which include questions on drug use. Descriptions of the main surveys used for monitoring the prevalence of illicit drugs in the UK can be found at the end of this chapter.

In England and Wales, for which the most complete time series data are available, prevalence of last year use of any illicit drug among the adult population had been fairly stable at around 12% between 1998 and 2003/04, then decreasing steadily to 9.4% in 2007/08; and then falling again to 8.5% in 2009/10. Since then, the prevalence of last year use of any illicit drug has fluctuated between eight and nine per cent. GPS indicate that cannabis is the most commonly used illicit drug in the UK and it has been in each year that relevant surveys have been conducted. Due to its relatively high prevalence, cannabis is a substantial driver of overall drug trends. Cocaine is the next most commonly used drug, followed by ecstasy. Cocaine prevalence reported through surveys reached a peak in 2007/08 but has also since declined, although this has increased in the most recent surveys.

Although its use in the general population is relatively uncommon, heroin is associated with causing substantial health and social harms to users as well as harms to society in the form of drug-related crime and, as such, is of particular importance to policy makers in the UK. Around 80% of people in treatment for issues with drugs cite heroin as a problematic substance.

3.2 Overview of cannabis

Cannabis is the most commonly reported drug used in GPS carried out in each country of the UK, and it has been in each year that any of these surveys has been conducted. Last 12 month prevalence in the most recent CSEW stands at 6.7%, compared with 2.3% of respondents using cocaine (the next most commonly reported illicit drug) (Home Office, 2015f). Use of cannabis in the general population has been on a long-term downward trend since 2003/04, but the trend since 2009/10 has been relatively flat. Use of cannabis is most common among younger respondents and the long-term downward trend is also more apparent among this group, with last year prevalence for 16-24 year olds decreasing from a high of 28.2% in 1998 to 16.3% in 2014/15. However this declining trend may be levelling out (Home Office, 2015f).

The proportion of those who reported having used cannabis in the last year having done so more than once a month has fallen in recent years, from 52.0% in 2009/10 to 46.0% in the last CSEW (Home Office, 2015f). However, this remains a very high proportion of last year users compared to other drugs (excluding heroin for which household survey data is not reliable). Furthermore, those using cannabis in the last month are more likely to have used more than once a week than users of other commonly reported drugs.

The greater prevalence of use of cannabis compared with other illicit drugs is also reflected in seizures data, with cannabis being involved in far more seizures than any other illicit drugs (see section 9.5.1).

Despite the fall in prevalence of cannabis use since 2003/04 there has been an increase in the number of people accessing treatment for this drug over the same period (see section 5.4.4). There is no universally accepted explanation for the divergence in these trends. Rising treatment presentations may indicate a greater proportion of users experiencing harms from their cannabis use (potentially as result of increasing potency). However, this could also indicate improving treatment penetration of those cannabis users in need of drug treatment.

3.3 Overview of the most commonly used stimulants

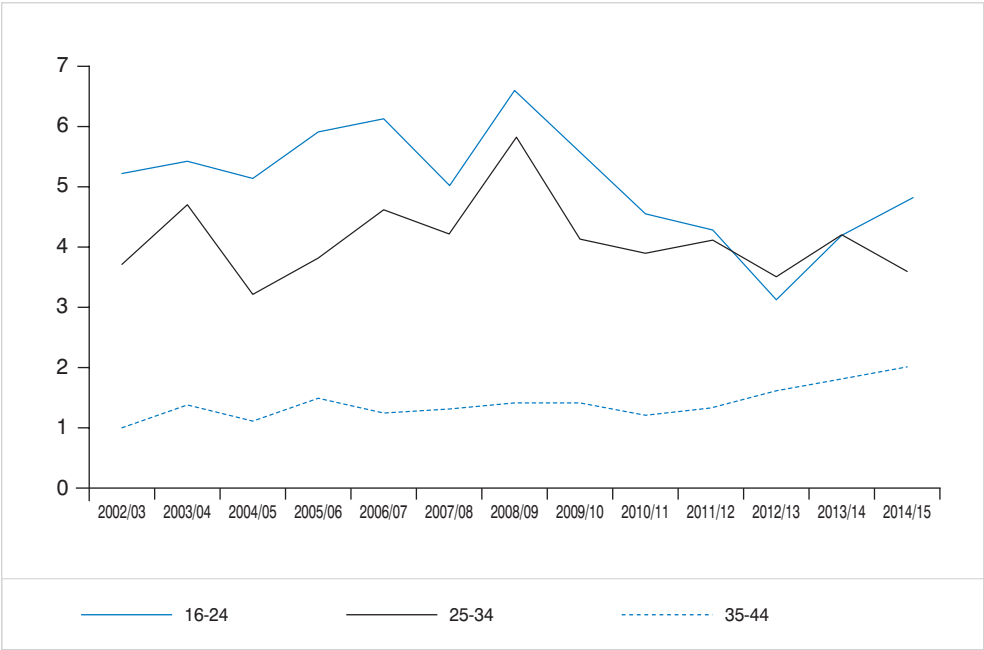
There has been a small long-term downward trend in the overall use of any stimulant drug²³ among 16-59 year olds reported in the CSEW since the beginning of the time series, from 4.4% in 1996 to current levels of around 3.5%. The dip to three per cent reported in 2012/13 appears not to be reflective of the longer term trend (Home Office, 2015f).

Cocaine

Powder cocaine is the most prevalent stimulant in the UK and the second most prevalent drug overall, with last year use reported at 2.3% in the latest CSEW (Home Office, 2015f).

Since 2008/09, an overall fall in the prevalence of cocaine use has been reported by the CSEW among all ages. This appears to have been driven by lower levels of use in younger age groups, suggesting there were fewer initiates among this generation. However, the drop off was not seen in the 35 to 44 group; indeed, prevalence amongst this group has increased over the last decade to two per cent in 2014/15. The increasing prevalence in this age bracket may indicate that a greater proportion of people from this generation are continuing to use cocaine as they transition into middle age than was the case among those born a few years earlier.

Figure 3.1: Trends in last year cocaine use amongst under 45s in England and Wales, 2002/03 to 2014/15, by age group



Source: ST01

²³ 'Any stimulant drug' in the CSEW comprises powder cocaine, crack cocaine, ecstasy, amphetamines and amyl nitrite, plus methamphetamine since 2008/09 interviews and mephedrone since 2010/11 interviews.

The proportion of last year users of cocaine who reported using in the last month in the CSEW has fallen each year in which the question was asked, from a high of 43.6% in 2006/07 to a record low in 2013/14 of 13.5%.

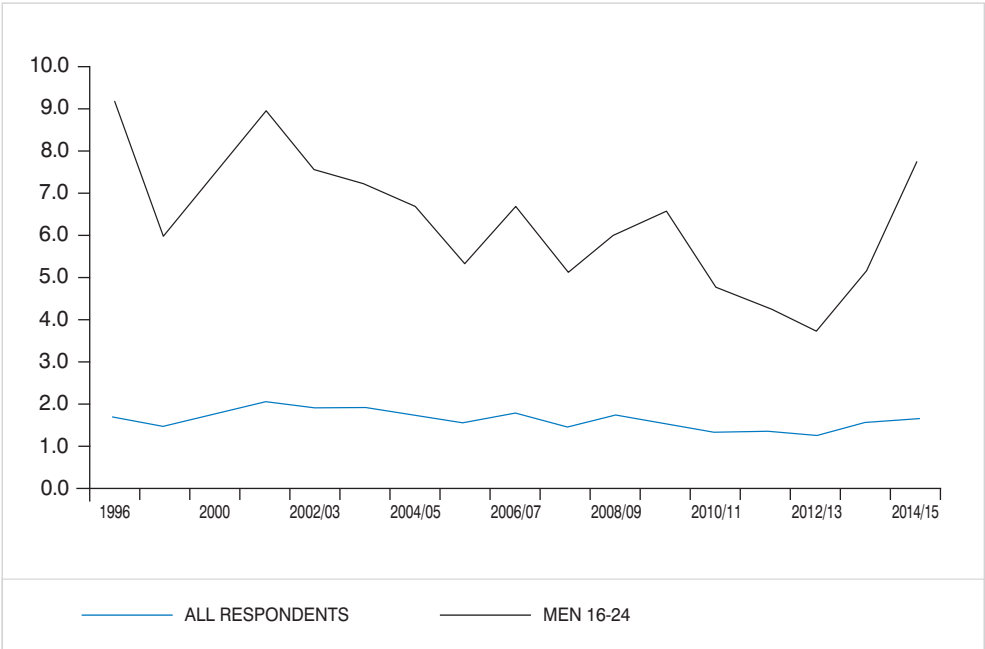
The same level of last year cocaine use reported by the CSEW was also observed by the most recent survey in Scotland (2.3%) (Scottish Government, 2014b). Last year cocaine prevalence in Northern Ireland was slightly lower at 1.5% in 2010/11 (National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIRB), 2012).

Among the general population, use of powder cocaine is far more common than use of crack cocaine. Although crack cocaine use is relatively rare, it is associated with very problematic use and drug-related crime, predominantly among those also using opioids. Due to the often chaotic nature of users' lives, it is likely that household surveys underestimate crack use. The last indirect estimate of problematic crack use in England puts the rate at 4.76 per 1000 population aged 15 to 64 years (Hay, Rael dos Santos, & Worsley, 2014). Cocaine (powder) is also the most seized stimulant in the UK, both in terms of number and quantity of seizures (see ST13). Having been 51% in 2003, the purity of domestic resale powder cocaine fell to 20% in 2009. However, it has risen since then and was 36% in 2014.

Ecstasy

Ecstasy (MDMA) is the second most commonly reported stimulant from UK household surveys (for example, last year use was reported as 1.7% in the 2014/15 CSEW). Following a gradual decline in ecstasy prevalence among the general population, as reported in the CSEW, which was reflective of overall stimulant use, there has been a small (but not statistically significant) increase in the rate reported since 2012/13. This increase appears far more pronounced in men aged 16 to 24 for whom the prevalence rate reported in 2014/15 was higher than in any year since 2001/02 and at least a clear percentage point higher than in the previous 10 surveys. However, these differences have not been tested for significance.

Figure 3.2: Trends in last year ecstasy use amongst all respondents and 16 to 24 year old men in England and Wales, 1996 to 2014/15



Source: (Home Office, 2015f)

The proportion of last year users of ecstasy who reported using in the last month in the CSEW has fallen each year in which the question was asked, reaching a record low in 2013/14 of 3.8%, having been 35.9% in 2003/04 when this was first included in the survey. There was a pronounced drop between 2008/09 and 2009/10 from 28.0% to 12.5%. Substitution with mephedrone is one possible explanation for this drop; however, prevalence of mephedrone was not included in the survey until 2010/11. Findings from the CSEW also suggest a relatively small proportion of people who use ecstasy do so more than once a month (four per cent compared with 13% and 12% of cocaine and amphetamine last year users respectively) (Home Office, 2015f).

The age profile for ecstasy is younger than cocaine and amphetamines. It is sold in powder/crystal form as well as in pills. Purity has risen in recent years, with batches of super-strength tablets causing some concern. After having dropped sharply to a low in 2009, deaths in England involving MDMA have risen in recent years to levels similar to those seen before the drop. However, aside from MDMA itself, there have been several deaths since 2011 resulting from overdoses of the far more toxic substances PMA and PMMA which are likely to have been sold to users as ecstasy.

Amphetamine

Despite a long-term downward trend in prevalence of use of amphetamine, this remains one of the most commonly reported stimulants in surveys (0.6% in the last CSEW) (Home Office, 2015f). Although prevalence of use of amphetamine is lower than ecstasy, the overall numbers of amphetamine seizures in the UK are roughly twice that of ecstasy. This may indicate that amphetamine users are more likely to come into contact with police and/or that amphetamine users may (like crack or heroin users) be less well represented in household surveys than users of other drugs (Home Office, 2015f).

Mephedrone

Of all the stimulant new psychoactive substances (NPS), mephedrone is the only one to have become established alongside traditional substances among recreational drug users within the general population. Although prevalence has fallen since mephedrone was controlled in 2010, it remains at 0.5%, having been 1.3% (akin to ecstasy) in 2010/11 (the first year for which mephedrone prevalence was collected on the CSEW). Like ecstasy, the age distribution of mephedrone users is younger than that of either cocaine or amphetamine. Almost all users of mephedrone report also having used other illicit drugs, suggesting that mephedrone is more likely to be used by existing users of drugs rather than new users being initiated into drug taking behaviour (Home Office, 2011). Use of mephedrone is of concern among specific groups such as injecting problematic drug users (particularly in Wales) and men who have sex with men (MSM) due to its association with chemsex.

Khat

Khat became controlled as a Class C drug in June 2014. The 2014/15 CSEW reported a significant fall in the consumption of Khat, with 0.04% of respondents aged 15 to 59 years reporting using the drug in the last year compared with 0.2% in 2011/12 when Khat use was last measured by the CSEW²⁴ (Home Office, 2015f).

3.4 Overview of heroin and other opioids

Heroin is the most commonly used illicit opioid in the UK. While some non-opioid drugs including cannabis, cocaine and ecstasy are used by a larger proportion of the population, heroin is associated with causing the most health and social harm to users as well as harms to society in the form of drug-related crime. As such, heroin is of key importance to policy-makers in the UK. The misuse of opioids prescribed for pain-relief (e.g. tramadol and codeine) among the general population is a concern particularly given the increasing practice of prescribing such medicines. There is currently limited data to

²⁴ Khat is generally used by individuals of a specific national origin; therefore, household surveys such as the CSEW in their general population estimates may not adequately capture levels of use of low prevalence drugs within such a small subgroup of the population.

monitor this issue, but the UK is not considered to have a problem similar in scale to that of the USA.²⁵ The 2014/15 CSEW included a question for the first time on the misuse of prescription-only painkillers, asking respondents whether they had taken prescription-only painkillers not prescribed to them, which they took only for the feeling or experience it gave them. Approximately 5.4% of adults aged 16 to 59 had misused a prescription-only painkiller not prescribed to them in the last year (Home Office, 2015f).

Medications prescribed in opioid substitution treatment (OST) are sometimes diverted from the treatment system and, as such, methadone and buprenorphine also form part of the range of drugs used illicitly by the problem opioid using population. Supervised consumption, the need for which is determined in accordance with clinical guidelines (Department of Health England and the devolved administrations, 2007), was introduced in the late 1990s and is an effective way of reducing diversion (Strang, 2010). Given both the source of supply and the population at risk of abusing them, diverted OST medications may be considered an adjunctive issue to the heroin problem.

England, Scotland and Wales all commission regular indirect estimates of their problem drug using populations and they each include problem opioid users within their definitions. While none of the studies include estimates of the number of users of specific opioids, based on the methods used, the target populations are made up principally of current heroin users as well as former users who are successfully managing their problem through OST. UK Focal Point estimates there are about 370,000 problem drug users in the UK (see section 3.5). Due to their often chaotic lives, problem opioid users are greatly underrepresented in household surveys. Nevertheless, among respondents who reported having ever used illicit opioids in the most recent CSEW, similar numbers reported having used illicit methadone as reported having used heroin (both less than one per cent of respondents). It should be noted that the relative use of these substances among opioid users responding to the CSEW may not be reflective of that in the wider opioid using population (Home Office, 2015f).

Of the 50,592 Treatment Demand Indicator (TDI) cases in 2014 citing an opioid as their primary problem substance on entering treatment, 85% cited heroin compared with four per cent each citing one of either illicit methadone or buprenorphine. Of all the 100,456 TDI cases heroin was cited as a secondary drug in just three per cent of cases, indicating that heroin is almost always seen as the most problematic substance for those who use it. A further two per cent and one per cent respectively cited illicit methadone and illicit buprenorphine as a secondary drug.

In terms of drug seizures, a far greater quantity of heroin is seized each year in the UK than is seized of other opioids (see ST13). A negligible quantity of methadone is seized by Border Force suggesting diversion from OST is the only significant source of illicitly used methadone in the UK.

3.5 Estimates of High Risk Drug Use

Due to the association between illicit opioid use and both individual and societal harms, estimating the size of the problem opioid using population is a key element of the evidence base used to formulate policy and inform service provision. It additionally provides a context in which to understand the population impact of interventions to reduce drug-related harm. Direct enumeration of those engaged in a largely covert activity such as the use of heroin is not possible, and household surveys such as the CSEW tend to underestimate numbers of those individuals whose drug use is the most problematic (Home Office, 2015f). However, indirect techniques can be applied to provide estimates of high risk drug use prevalence.

Estimates of high risk drug use (HRDU) in the UK are derived using two indirect measurement techniques: the capture-recapture (CRC) method; and the multiple-indicator method (MIM). Since 2006, all four UK administrations have published prevalence estimates to meet their policy requirements. The drugs, data and time periods covered by these estimates differ across the administrations. In England, estimates are produced for opioid and/or crack cocaine users (OCUs) (together and separately) and injecting among users of those drugs. In Scotland, HRDU refers to the problematic use of opioids and/or the illicit

²⁵ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/456464/ACMD_DISM_Interim_Advice_-_Aug_15.pdf

use of benzodiazepines and drug injecting. Wales have commissioned a new suite of estimates over 11 years with an expanded scope. The last published estimates look at long duration or regular use of opioids, cocaine powder and/or crack cocaine. The last estimates in Northern Ireland covered 2004 and estimated high risk opioid and/or problem cocaine powder use.

In England, the latest national and regional estimates are for 2011/12 for OCU, with separate estimates available for opioid use, crack cocaine use, and injecting drug use. It should be noted that the case definition focuses on the 'use' of opioids and/or crack cocaine rather than the 'misuse'/addiction to these drugs. The estimates therefore include people using prescribed opioids such as methadone or buprenorphine. In Scotland, the latest national and regional estimates for problematic opioid and/or benzodiazepine use are for 2012/13. In Wales, local and national estimates for 2009/10 for long duration or regular use of heroin, other opioids, crack cocaine and/or cocaine powder were published in 2011 (UK Focal Point, 2012). Estimates for Northern Ireland for 2004 were published in 2006 and cover problem opioid and/or problem cocaine powder use (UK Focal Point, 2006).

Table 3.1: The estimated number of high risk drug users: number and rate per 1,000 population aged 15 to 64, by country

COUNTRY	ESTIMATE	95% CONFIDENCE INTERVAL		RATE	95% CONFIDENCE INTERVAL	
England	293,879	291,029	302,146	8.40	8.32	8.63
Scotland	59,500	57,500	61,600	16.8	16.3	17.4
Wales	30,443	23,172	38,809	15.72	11.96	20.04

Source: (Hay et al., 2014; Information Services Division, 2011; Welsh Assembly Government, 2011)

The estimates produced by UK Focal Point relate to high risk drug use and incorporate each of the definitions used by the three administrations included (as listed above). Based on the 2011/12 English estimate (Hay et al., 2014) and the 2009/10 Scottish and Welsh estimates (Information Services Division, 2011; Welsh Assembly Government, 2011), it is estimated that there are 371,279 (CI: 364,418 – 388,306) HRDUs in the UK,²⁶ a rate of 9.16 per 1,000 population (CI: 8.99 – 9.58) aged 15-64 (Table 3.2). For consistency with the rest of the time-series, the original method Welsh HRDU estimates for 2009/10 have been used.

Table 3.2 shows the HRDU estimates for Great Britain since 2007.²⁷ The 'year of estimate' refers to the year the estimate was reported by the UK Focal Point rather than the year the estimate is for.

Between 2007 and 2009 there was an increase in HRDU in Great Britain from 399,150 (CI: 397,267 – 420,767) to 404,876 (CI: 393,088 – 430,575), but this has since declined to the 371,279 estimated HRDU in 2014. This also represents a reduction in the rate per 1,000 population from 10.41 (CI: 10.36 – 10.98) in the 2007 estimate to 9.16 (CI: 8.99 – 9.58) in the 2014 estimate. The reduction in HRDUs in Great Britain has been driven by a fall in the number of opioid users.

²⁶ Northern Ireland have been excluded due to the age of the latest estimates available

²⁷ In 2014, the UK Focal Point revised the methodology to calculate UK estimates of HRDU. Previous UK estimates have taken the approach of summing published figures of both the reference population and the number of HRDUs from each devolved administration to arrive at a UK estimate of HRDU. These estimates were based on different years of data and this approach created an artificially derived UK population estimate. From 2014 onwards, population estimates that correspond to the latest year of HRDU estimate will be utilised when calculating a UK HRDU estimate. Furthermore, as opposed to summing the number of HRDU for each of the published estimates, the latest published rates of HRDU from each devolved administration will be applied to the most recent population estimate. This slight methodological change is unlikely to result in any major changes to the estimate. Following the UK 2011 census, the Office for National Statistics (ONS) published updated population estimates covering the period 2001-2010 (see: http://www.ons.gov.uk/ons/dcp171778_345500.pdf). Considering the changes to the UK HRDU methodology, and in turn the resulting comparability of trends, the UK Focal Point has retrospectively amended all UK HRDU estimates based on these refreshed population estimates with the aim of increasing comparability across years.

Table 3.2: The estimated number of high risk drug users: number and rate per 1,000 population, aged 15 to 64 in Great Britain, by year of estimate*

YEAR OF ESTIMATE**	ESTIMATE	95% CONFIDENCE INTERVAL		RATE	95% CONFIDENCE INTERVAL	
2007 ²⁸	399,150	397,267	420,767	10.41	10.36	10.98
2008 ²⁹	404,832	396,566	424,904	10.45	10.23	10.96
2009 ³⁰	404,876	393,088	430,575	10.34	10.04	11.00
2010 ³¹	396,793	386,600	418,982	10.04	9.78	10.60
2011 ³²	379,953	369,114	399,647	9.54	9.27	10.04
2012 ³³	385,067	373,827	404,498	9.62	9.34	10.11
2013 ³⁴	378,269	370,101	395,347	9.40	9.19	9.82
2014 ³⁵	371,279	364,418	388,306	9.16	8.99	9.58

*Data has been revised according to new methodology and will therefore not match previous reports

**Refers to the year in which the estimate was produced rather than the year the estimate relates to

Source: ST07

3.6 Injecting drug use

There are current concerns about the changes in the patterns of psychoactive drug injection in the UK, in particular the increased injection of amphetamine-type stimulants and the emergence of the injection of NPS. This has occurred at a time when there has probably been a decline in the injection of opiates and of crack-cocaine in England at least.

Data from the Unlinked Anonymous Monitoring (UAM) survey of people who inject drugs (PWID) indicates that the proportion of people in England, Wales and Northern Ireland reporting injecting amphetamines and amphetamine-type drugs as their main drug rose from 3.9% (58/1,460) in 2004 to 12% (159/1,354) in 2014, though opioids remained the most common main drugs injected (Figure 3.3) (Public Health England, 2014b).

²⁸ 2007 estimate is based on estimates of opioid and/or crack cocaine use in England for 2004/05 (Hay et al., 2006), and opioid and/or benzodiazepine use in Scotland, 2003 (Hay, Gannon, McKeganey, Hutchinson, & Goldberg, 2004). Estimates for Wales are extrapolated from the estimates for England.

²⁹ 2008 estimate is as 2007 above, except for England which refers to 2005/06 (Hay et al., 2007)

³⁰ 2009 estimate is based on estimates of opioid and/or crack cocaine use in England for 2006/07 (Hay et al., 2008), opioid and/or benzodiazepine use in Scotland for 2006 (Hay, Gannon, Casey, & McKeganey, 2009) and long duration or regular use of opioids, powder cocaine and/or crack cocaine in Wales for 2006/07 (Welsh Assembly Government, 2009).

³¹ 2010 estimate is as 2009 above, except for England which is based on estimates of opioid and/or crack cocaine use for 2008/09 (Hay, Gannon, Casey, & Millar, 2010).

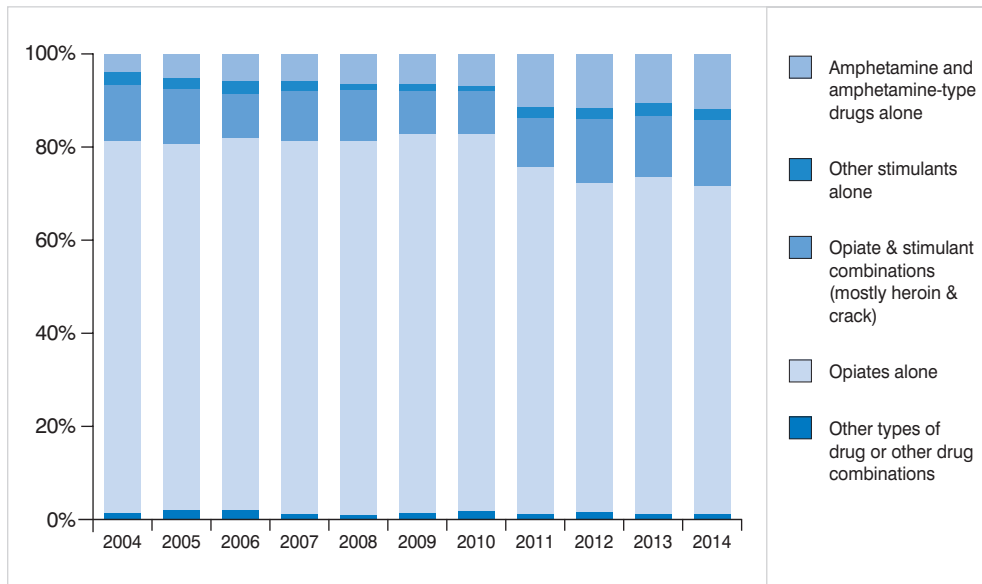
³² 2011 estimate is based on estimates of opioid and/or crack cocaine use in England for 2009/10 (Hay, Gannon, Casey, & Millar, 2011), opioid and/or benzodiazepines use in Scotland for 2006 (Hay et al., 2009), and long duration or regular use of opioids and/or crack cocaine/ cocaine powder in Wales for 2009/10 (Welsh Assembly Government, 2011).

³³ 2012 estimate as 2011 above, except for Scotland which is based on estimates of opioid and/or benzodiazepine misuse in Scotland for 2009/10 (Information Services Division, 2011).

³⁴ 2013 estimate is as 2012 above, except for England which is based on estimates of opioid and/or crack cocaine use in 2010/11 (Hay, Rael dos Santos, & Millar, 2013).

³⁵ 2014 estimate as 2013 above, except for England which is based on estimates of opioid and/or crack cocaine use in England for 2011/12 (Hay et al., 2014).

Figure 3.3: Main drug type injected among those currently* injecting psychoactive drugs in England, Wales and Northern Ireland: 2004 to 2014



*Among those who had injected during the preceding 28 days.

Source: (Public Health England, Health Protection Scotland, Public Health Wales, & Public Health Agency Northern Ireland, 2015)

There have been concerns about the emergence of the injection of NPS, particularly mephedrone and other synthetic cathinones. In England, Wales and Northern Ireland, 5.9% (92/1,554) of those participating in the UAM Survey during 2014 reported that they had injected mephedrone during the preceding month, and 8.9% (184/2,054) had injected this drug at some point during the preceding year (Public Health England et al., 2015).

In Scotland, among people who injected drugs during the last six months surveyed at services providing injecting equipment, heroin was the most commonly injected drug, at over 93% between 2008 and 2012. The proportion reporting amphetamines as their main drug of injection in the last six months was typically very low, and was 1.3% (23/1,800) in 2011/12. Reports of any other amphetamine-type drugs were also rare, with less than one per cent of respondents reporting injection of these drugs in each survey year (Public Health England et al., 2015).

In 2014 a section of the injecting population in the Edinburgh area began to inject ethylphenidate-based NPS with brand names such as Burst and Blue Stuff. Health, social care and police all reported a rapid increase in chaotic and aggressive behaviour. These short-acting, but intense stimulants were easily accessible from a number of shops across the area. From October 2014 presentations of extensive, necrotic-style wounds were common and over the next six months 200 individuals were infected with *Staphylococcus aureus* and Group A *Streptococcus*. The Group A strep was almost exclusively typed as M76. An incident management team has been addressing this outbreak. It is thought that the spread of the infection is via person-to-person contact, and not through contamination of the products, though this cannot be fully ruled out. The UK-wide Temporary Class Drug Order (TCDO) banning the sale and distribution of ethylphenidate reduced the high street access to this drug, and seems to have slowed the number of new infections amongst the injecting population; however many are still experiencing physical harms and poor mental health as a result of their polydrug use.

There is an ongoing decline in the numbers of drug users injecting opioids and crack-cocaine in England (National Treatment Agency for Substance Misuse, 2010). However, opioids continue to be the most commonly injected drug, (see Figure 3.3) with around 70% of PWID reporting injecting opioids alone, a decline from the higher percentage reported before 2010 (over 80%) (Public Health England et al., 2015).

3.7 Image and performance enhancing drugs

In recent years there have been growing concerns related to the use of image and performance enhancing drugs (IPEDs). However, only limited information exists regarding the prevalence of use of these substances. The latest CSEW estimates that in 2014/15 prevalence among 16 to 59 year olds for lifetime use of anabolic steroids was 293,000 (range 242,000 – 345,000) and for use in the previous 12 months, 73,000 (range 48,000 – 99,000). This represents approximately a nine per cent increase compared to the relative 2013/14 figures (Home Office, 2015j). Moreover, data from the CSEW indicates that lifetime prevalence of anabolic steroid use among 16 to 59 year olds has risen over time from 0.5% in 2004/05 to 0.9% in 2014/15, a substantial 80% increase (Home Office, 2015j).

In July 2015 the results of the second IPED online survey were published (McVeigh, Bates, & Chandler, 2015). One hundred and eight people from the UK took part in the survey which represents an emergent platform to provide evidence-based information and advice to reduce the harms associated with the use of IPEDs. Participants were aged between 17 and 64 years old with a mean age of 33 years, and the vast majority of respondents reported taking IPEDs both orally and via injection (McVeigh et al., 2015). The most commonly used substances taken orally were anabolic steroids (65%); nearly two-thirds (64%) of participants had injected testosterone enanthate in the past year and 16% reported injecting the tanning agents melanotan I or II in the previous 12 months. The survey also found evidence of the concurrent use of psychoactive drugs, with 32% of participants reporting use of psychoactive drugs, particularly cocaine and cannabis, in the previous year (McVeigh et al., 2015). The survey concluded that the IPED market is very dynamic and fast paced with practices and preferences of this population sub-group frequently changing along with the associated health risks. Consequently the main public health concerns for people using IPEDs remain those related to the risks associated with injecting practices and with transmission of blood borne viruses (BBVs) (see section 6.2.2).

3.8 Drug use in the school population

Smoking, drinking and drug use amongst young people in England

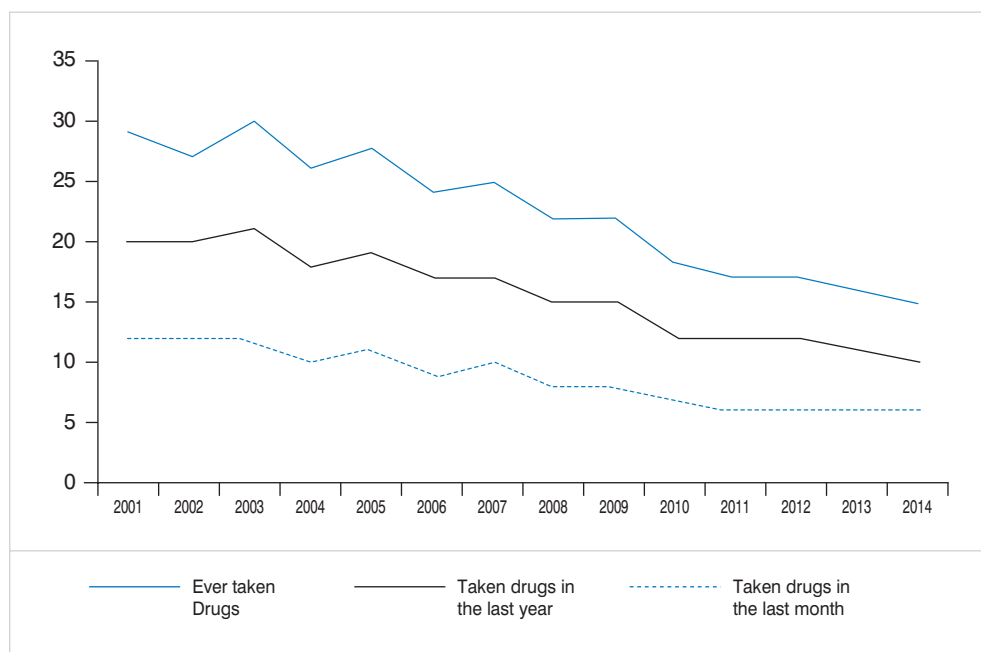
Data from the *Smoking, drinking and drug use among young people in England* survey (SDD) showed that the prevalence of drug use among 11 to 15 year olds in England is continuing to decline, although at a slower rate than in the period between 2001 and 2010 (Fuller, 2015).

In 2014, 14.6% of pupils aged 11 to 15 years old had ever taken drugs, 10.3% had used drugs in the last year (recently), and 6.1% had used drugs in the last month (Table 3.3). Cannabis was the most prevalent drug, with 6.7% of pupils having used it in the last year. Volatile substances³⁶ were the second highest, with 2.9% of pupils having used them recently.

The proportion of pupils (aged 11 to 15) reporting use of stimulants in the last year has come down from 6.9% in 2007 to 2.1% in 2014. The decline in prevalence rates over this period was most prominent for poppers which had been the most commonly reported stimulant in the SDD in 2007, with 4.9% reporting use in the last 12 months compared with 1.8% for cocaine (the next most prevalent stimulant) (Fuller, 2015). Only 0.7% reported using poppers in the last 12 months in the 2014 SDD compared with 0.9% reporting cocaine.

³⁶ Glue, gas, aerosols or solvents.

Figure 3.4: Proportion of pupils aged 11 to 15 years who have taken drugs ever, in the last year and in the last month, 2001-2014



Source: (Fuller, 2015)

Scottish Schools Adolescent Lifestyle and Substance Use Survey

The *Scottish Schools Adolescent Lifestyle and Substance Use Survey* (SALSUS) was last carried out in 2013, and results were published in November 2014 (Information Services Division, 2014b).

The key findings were:

- one-fifth of 15 year olds (18%) and four per cent of 13 year olds had ever used drugs;
- one-sixth of 15 year olds (16%) and three per cent of 13 year olds had used drugs in the last year;
- cannabis was the most commonly used drug for both ages and across all recall periods;
- 15 year old boys were more likely than girls to be recent (17% compared to 14%) and current (11% compared to eight per cent) drug users;
- at age 13, drug use was similar for boys and girls (last year use was four per cent for boys and three per cent for girls, and last month use was two per cent for both); and
- among 15 year olds, synthetic cannabinoids including Spice³⁷ (two per cent) followed by mephedrone and salvia (both at one per cent) were the most commonly used NPS.

The survey also reported that five per cent of 15 year olds reported ever using stimulants, compared with one per cent of 13 year olds. Cocaine and ecstasy were also the most commonly used stimulant drugs (two per cent in the last 12 months) by 15 year olds with a smaller proportion (one per cent or less) of 13 year olds using them (Information Services Division, 2014b).

³⁷ In the SALSUS Spice was previously listed as a separate drug.

Table 3.3: Percentage of pupils aged 11 to 15 years reporting lifetime, last year and last month use of individual drugs in England in 2014, by gender

	LIFETIME USE			LAST YEAR USE			LAST MONTH USE		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Any drug	15.7	13.5	14.6	10.8	9.8	10.3	6.5	5.7	6.1
Amphetamines	1.1	0.8	0.9	0.8	0.5	0.7	0.5	0.2	0.3
Cannabis	8.8	7.2	8.0	7.2	6.2	6.7	4.4	3.4	3.9
Cocaine powder	1.3	0.8	1.0	1.1	0.6	0.9	0.6	0.2	0.4
Crack cocaine	0.5	0.4	0.5	0.3	0.3	0.3	0.3	0.2	0.2
Ecstasy	1.2	0.8	1.0	1.0	0.6	0.8	0.5	0.3	0.4
LSD	0.8	0.4	0.6	0.7	0.3	0.5	0.4	0.1	0.3
Magic mushrooms	1.2	0.7	1.0	1.1	0.5	0.8	0.5	0.2	0.4
Poppers	1.0	0.6	0.8	0.9	0.4	0.7	0.5	0.2	0.3
Mephedrone	0.5	0.5	0.5	0.5	0.5	0.5	0.4	0.3	0.4
Opioids	0.8	0.5	0.6	0.5	0.3	0.4	0.4	0.2	0.3
Volatile substances	6.8	5.9	6.4	2.8	3.0	2.9	1.5	1.7	1.6
Base	3104	3104	3104	3011	3011	3011	6115	6115	6115

Source: (Fuller, 2015)

3.9 New psychoactive substances

Prevalence of NPS use reported in surveys is low compared to the main traditional illicit drugs in the UK. In the 2014/15 CSEW, 0.9% of those aged 16 to 59 said they had used NPS in the previous 12 months and 2.9% had used NPS as some point in their lifetime (Home Office, 2015j). NPS use is higher in younger adults, with 2.8% of 16 to 24 year olds (174,000 people) having used NPS in the last year. Data from the SDD (Fuller, 2015) show that 2.5% of pupils aged 11 to 15 had used NPS at least once in their lifetime. In the latest SALSUS, four per cent of pupils aged 15 reported having used one or more NPS in their lifetime³⁸. Among 15 year olds, the most commonly offered and used NPS were synthetic cannabinoids (five per cent), followed by mephedrone (three per cent) and salvia (three per cent) (Information Services Division, 2014b). Use of NPS, particularly synthetic cannabinoids, among the prison population is an area of concern (see section 8.7.1).

3.10 Sources of information on the prevalence of drugs

Below are descriptions of the main surveys used for monitoring trends in the prevalence of drug use in the UK.

The Crime Survey for England and Wales

The CSEW (formerly the *British Crime Survey*) is an annual survey which gathers information about experience of crime in England and Wales. It is designed to provide a complementary measure of crime to police recorded crime statistics. It was first carried out in 1982, and since 2001/02 it has been a continuous survey. Since 1996, it has also asked respondents aged 16 to 59 about their use of illicit

³⁸ The NPS reported in the SALSUS 2013 are: GHB/GBL, mephedrone, salvia, synthetic cannabinoids (including Spice), and powders and/or pills that are sold as 'legal highs'.

drugs in a self-completion module using Computer Assisted Self Interviewing (CASI). Since 2009 there has been an additional survey element covering 10 to 15 year olds' experience of crime. This includes questions on drinking and cannabis use but the main focus is on victimisation. The annual school surveys are the main source of data on drug use among children.

The Scottish Crime and Justice Survey

The **Scottish Crime and Justice Survey** (SCJS) (previously the Scottish Crime and Victimization Survey (SCVS) and the Scottish Crime Survey) is similar in scope and aims to the CSEW, although questions on drug use are asked of all respondents aged 16 years and over. The latest published results are for 2012/13. Surveys were carried out as part of the former British Crime Survey (BCS) in 1982 and 1988; as the independent Scottish Crime Survey in 1993, 1996, 2000, 2003; as the SCVS in 2004, 2006; and as the SCJS in 2008/09, 2009/10, 2010/11 and 2012/13. The survey asks questions about drug use using Computer Assisted Personal Interviewing (CAPI).

The Northern Ireland Crime Survey

The **Northern Ireland Crime Survey** (NICS) is also similar to the CSEW. Surveys containing a drug use module were carried out in 1994/95, 1998, 2001 and 2003/04 and the survey became continuous from January 2005. However, after March 2009 the drugs module was no longer included, hence the last published results on drug use were for 2008/09. In addition, a Drug Prevalence Survey, based on the EMCDDA model questionnaire, was carried out in Northern Ireland (and Ireland) in 2002/03, 2006/07 and 2010/11 among people aged 15 to 64 years old using CAPI.

Smoking, Drinking and Drug Use among Young People in England

The SDD is carried out by NatGen Social Research and the National Foundation for Educational Research (NFER) on behalf of the Health and Social Care Information Centre (HSCIC). It is an annual survey and provides national estimates and information on the smoking, drinking and drug use behaviours of young people aged 11-15 (it is carried out by pupils in years 7-11).

In England each year around one in ten secondary schools are randomly selected to take part in the survey. Different schools are chosen each year and schools are never asked to take part two years in a row. Around 35 pupils from each school are randomly selected to take part anonymously to the survey. The survey provides information on:

- prevalence of smoking, drinking and drug taking among school children;
- the number of pupils who have never smoked, drunk alcohol or taken drugs;
- types of alcohol and drugs taken;
- how often pupils smoke, drink and take drugs;
- where pupils obtain cigarettes, alcoholic drinks and drugs;
- pupils' attitudes to these behaviours; and
- predictors of the likelihood of smoking, drinking and drug use among school children.

Scottish Schools Adolescent Lifestyle and Substance Use Survey

The latest SALSUS report was published in November 2014. The research was commissioned by the Scottish Government and undertaken by NHS Information Services (ISD Scotland), National Services Scotland and Ipsos MORI Scotland. It is a biennial survey and provides estimates and information on the smoking, drinking and drug use behaviours of young people aged 13 and 15.

The survey provides information on:

- prevalence and trends in smoking, drinking and drug use among young people at Scotland level;
- disaggregated data at Alcohol and Drug Partnership (ADP), Local Authority and NHS Board level;
- patterns of behaviour in relation to smoking, drinking and drug use;
- sources of cigarettes, alcohol and drugs;
- pupils' attitudes to substance use;
- the attitudes of families and friends to substance use; and
- contextual information on the relationship between substance use and other lifestyle, health and social factors.

The Young Persons' Behaviour and Attitudes Survey

The *Young Persons' Behaviour and Attitudes Survey* was undertaken in Northern Ireland in 2000 for the first time and repeated in 2003, 2007, 2010 and 2013.

Health Behaviour in School Age Children Survey

The *Health Behaviour in School Age Children Survey* (HBSC) provides data from Wales and is undertaken every four years with a two-year interim survey. The most recently published survey results are for 2009/10. Fieldwork for the 2013/14 survey has been carried out with results expected in 2014/15.

4. Prevention

4.1 Introduction

Reducing drug misuse is a key part of the United Kingdom (UK) Government's 2010 Drug Strategy which is aimed at *'creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so, and making it easier for those that do to stop'* (Her Majesty's Government, 2010) (see section 1.2.1). The 'Reducing Demand' strand of the 2010 strategy has recently been refreshed and now mixes universal actions aimed at all young people with targeted actions for those most at risk of using drugs or who have already started using drugs, and tackles the range of risk factors that make people vulnerable to substance misuse. This includes investing in a range of evidence-based programmes, which have a positive impact on young people and adults, giving them the confidence, resilience and risk management skills to resist drug use.

Since the late 1990s, many prevention programmes have been evaluated in the UK showing that the impact of drug education alone is unlikely to prevent young people from using drugs. It has been demonstrated that 'scare' approaches are likely to be ineffective, if not counterproductive. However, if drug education is delivered as part of a more holistic approach it can contribute towards a decrease in harmful behaviours, and increase safety for young people, their families and communities. Therefore, in recent years the focus of prevention policy has shifted away from interventions aimed specifically at drugs to strengthening general resilience factors associated with the aim of reducing the desire to explore risky behaviours including drug use (Faggiano, Minozzi, Versino, & Buscemi, 2014; James, 2011; UK Drug Policy Commission, 2012). A stronger emphasis has also been put on the importance of parents/carers and family influence on children's substance misuse and associated behaviours, and how early-life intervention, which should include prenatal family support, can reduce risk factors and strengthen the associated protective factors. Such intervention can include parenting skills education, support for families from pregnancy such as the Family Nurse Partnership, and parent and family skills training such as the Strengthening Families Programme (UK Focal Point, 2014).

The recent report by the Advisory Council on the Misuse of Drugs (ACMD), *Prevention of drug and alcohol dependence* (Advisory Council on the Misuse of Drugs, 2015b), highlighted a range of effective and ineffective practice in preventing substance misuse. There has also been a shift in how drug education and prevention programmes aimed at young people have been delivered. Early prevention strategies focused on approaches that provide information on the consequences of engaging in risky behaviour, usually targeting individual risky behaviour such as smoking, alcohol consumption, risky sexual behaviour, and drug use. Such approaches are based on the hypothesis that young people do not have a clear understanding of the potential consequences involved in participating in risky behaviour, and providing them with this information would make such behaviour less appealing. Often the information was provided using a passive form of learning, with very little or no participation from the targeted audience.

More recent education and prevention programmes also take into account the concept that young people's behaviour is affected by the perceived behaviour of their peers, in particular their tendency to overestimate the prevalence of risky behaviours amongst their peers. Therefore, providing them with information about the real prevalence of such risky behaviours might reduce their participation in such actions (such as the 'Social norm' approach (Chowdry, Kelly, & Rasul, 2013)). Some of these programmes tend to focus on relationships between individual behaviours and a range of social and environmental influences they are subject to, and the inter-relationship between individual behaviours as 'lifestyles', putting an emphasis on the need to communicate effectively with young people through a range of networks (such as web-based activity) and through the media, as well as through traditional school health education. These approaches have increasingly used social marketing methodologies, which advocate an integrated 'whole person' approach, to disseminate their message and to support behaviour change in young people, as well as in older groups (Andreasen, 2002).

Similar approaches to prevention are adopted by the devolved administrations; in Wales through *Rights of Children and Young Persons (Wales) Measure 2011* (Welsh Government, 2011). The Welsh Government in the *Working Together to Reduce Harm Substance Misuse Strategy Annual Report — 2014* (Welsh Government, 2014c) also emphasised the importance of delivering prevention messages within the workplace and that the early identification of young people at risk of engaging in risky behaviours can be an important aspect of prevention. The Getting It Right For Every Child (GIRFEC) programme³⁹ provides the methodology for delivering the Scottish Government's three social policy frameworks: the *Early Years Framework*; *Achieving our Potential*; and *Equally Well* (Scottish Government, 2008a), which aim to develop the prevention and early intervention agenda. More recently updated practice guidance, *Getting Our Priorities Right*, was developed in Scotland for agencies and practitioners working with children, young people and families affected by substance use (Scottish Government, 2013). This built on original guidance produced in 2003 (Scottish Government, 2006). In Northern Ireland, *Our Children and Young People – Our Pledge: A 10 year strategy for children and young people in Northern Ireland, 2006-2016* (Office of the First Minister and Deputy First Minister for Northern Ireland, 2006) sets a framework for addressing the needs of young people. Improved education and early interventions for young people and families (especially those most at risk) and improved public information about drugs are priority areas.

4.2 Environmental prevention

Environmental prevention strategies aim to alter the immediate cultural, social, physical and economic environments in which people make their choices about drug use.

4.2.1 Alcohol and tobacco policies in the United Kingdom

Across the UK there are a number of policies and strategy documents concerned with licit substances such as tobacco and alcohol. In Wales and Northern Ireland there are global strategies covering both illicit and licit substances.

Minimum unit pricing

Minimum unit pricing in Scotland, Northern Ireland and Wales

In 2009 the Sheffield Alcohol Research Group (SARG) at Sheffield University developed the Sheffield Alcohol Policy Model (SAPM) to evaluate the possible impact of alcohol policies (including different levels of Minimum Unit Pricing (MUP)) on the English population (Purshouse et al., 2009). Since then, the SAPM has been adapted to a range of international settings including Scotland, Wales and Northern Ireland (Angus, Scafato, et al., 2014; Hill-McManus et al, 2012; Meng, Brennan, & Meier, 2012).

Scotland

The Alcohol (Minimum Pricing) (Scotland) Bill was passed on 24th May 2012. The Bill received Royal Assent and became the *Alcohol (Minimum Pricing) (Scotland) Act 2012* on 29 June 2012.⁴⁰ The Scotch Whisky Association (SWA) (in conjunction with the European Spirits Organisation and the Comité Européen Des Entreprises Vins) sought a judicial review of this Act; this was held in January 2013, and found comprehensively in favour of the policy. The SWA et al. appealed that decision and following a hearing in February 2014 the case was referred to the Court of Justice of the European Union (CJEU) to clarify points of European Union (EU) law. On 3 September 2015 the Advocate General of the European Court of Justice stated that in their opinion the Scotland's Alcohol Minimum Unit Price (MUP) legislation does not contravene European law.⁴¹ Following this deliberation, the case will return to the domestic court to make its judgement in light of the CJEU's ruling.

³⁹ See: <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/publications/practice-guide>

⁴⁰ See: <http://www.legislation.gov.uk/asp/2012/4/contents/enacted>

⁴¹ See: <http://curia.europa.eu/juris/document/document.jsf?text=&docid=166846&pageIndex=0&doclang=en&mode=req&dir=&occ=first&part=1&cid=203295>

Table 4.1: United Kingdom strategy documents for alcohol, tobacco and illicit drugs

COUNTRY	SUBSTANCE(S) COVERED	REFERENCE
UK/England	Illicit drugs	<i>The Drug Strategy 2010, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'</i> (Her Majesty's Government, 2010)
	Alcohol	<i>The Government's Alcohol Strategy</i> (Her Majesty's Government, 2012a)
England	Tobacco	<i>Healthy Lives, Healthy People: A Tobacco Control Plan for England</i> (Her Majesty's Government, 2011a)
Wales	Illicit drugs and alcohol	<i>Working Together to Reduce Harm. The Substance Misuse Strategy for Wales 2008-2018</i> (Welsh Assembly Government, 2008b) <i>Working together to reduce harm. Substance misuse delivery plan 2013-2015</i> (Welsh Government, 2013)
	Tobacco	<i>Tobacco Control Action Plan for Wales</i> (Welsh Government, 2012)
Scotland	Illicit drugs	<i>Road to Recovery: A New Approach to Tackling Scotland's Drug Problem</i> (Scottish Government, 2008c)
	Alcohol	<i>Changing Scotland's Relationship with Alcohol: A Framework for Action</i> (Scottish Government, 2009a) <i>Changing Scotland's Relationship with Alcohol: A Framework for Action — Progress Report</i> (Government, 2012)
	Tobacco	<i>Scotland's Future is Smoke Free: A Smoking Prevention Action Plan</i> (Scottish Government, 2008d)
Northern Ireland	Illicit drugs and alcohol	<i>New Strategic Direction for Alcohol and Drugs Phase 2 2011-2016. A Framework for Reducing Alcohol and Drug-Related Harm in Northern Ireland</i> (Department of Health Social Services and Public Safety Northern Ireland, 2011a)
	Tobacco	<i>Ten-Year Tobacco Control Strategy of Northern Ireland</i> (Department of Health Social Services and Public Safety Northern Ireland, 2012)

Northern Ireland

In 2013, the Department of Health, Social Services and Public Safety (DHSSPS) and the Department for Social Development commissioned SARG to adapt the Sheffield Model to Northern Ireland (Angus, Meng, Ally, Holmes, & Brennan, 2014). The study modelled the potential impact of a range of MUP policies from 35-75 pence per unit of alcohol over a 20 year period. The study also separately modelled the impact of bans on below-cost selling and on price-based promotions in the off-licensed trade. The study concluded that MUP would be effective in reducing alcohol consumption, alcohol-related harms and the costs associated with them. It was estimated that the ban on below-cost⁴² selling would have almost no impact on the population's alcohol consumption and spending or on alcohol-related harms. However, a ban on price-based promotions in the off-licensed trade, either alone or in conjunction with a MUP policy, would be effective in reducing alcohol consumption, related harms and associated costs.

Following from the evidence provided by this study, in December 2014 the Northern Ireland Health Minister announced the intention to develop a policy to introduce MUP in Northern Ireland. A consultation paper is under development.

⁴² Below-cost selling refers to a ban on selling any alcoholic drinks for below the cost of duty plus the VAT payable on the duty.

Wales

In 2014 SARG was commissioned by the Welsh Government to adapt the Sheffield Model to the Welsh population and a report was published later in the year (Angus, Meng, et al., 2014). The Welsh analysis also modelled the possible impact of MUP policies ranging from 35-70p per unit of alcohol over a 20 year period. The study also looked at the estimated impact of a ban on below-cost selling. Analogous conclusions to those obtained by the application of SAPM to NI were found when the model was applied to Wales. However, the Welsh study did not look at the estimated impact of a ban on price-based promotions in the off-licensed trade.

The draft *Public Health (Minimum Price for Alcohol) (Wales) Bill*⁴³ was launched for consultation on 15 July 2015 and proposes:

- a formula for calculating the MUP using the Alcohol by Volume (ABV) measure;
- powers for Welsh Ministers to make subordinate legislation to set the MUP for alcohol sold or supplied in Wales;
- a duty on local authorities (LAs) to appoint authorised officers (AOs) to enforce the MUP and powers to prosecute; and
- a duty on LAs to enforce the MUP, including provision for powers of entry for AOs, an offence of obstructing an AO, and the power to issue fixed penalty notices

The consultation ran until 11 December 2015.

Drink and drug driving legislation

England and Wales

In March 2015 levels for the maximum blood concentration allowed for a selection of legal and illicit drugs for drivers was introduced in England and Wales. Limits are specified for eight illicit drugs such as cannabis, heroin and cocaine,⁴⁴ and eight medicines that are sometimes abused (the limits for these compounds are higher to reflect their medical use)⁴⁵ (see section 2.2.1).

Scotland

In December 2014 the legal blood alcohol limit for drivers in Scotland was reduced from 80mg in every 100ml of blood, to 50mg in every 100ml of blood, aligning Scotland with most other European countries.

Northern Ireland

Plans to tackle drink driving, including new lower legal blood alcohol limits, graduated penalties and increased police enforcement powers, are included in a Bill currently being considered by the Northern Ireland Assembly.⁴⁶ Subject to approvals, the current prescribed alcohol limit will be reduced from 80mg in 100ml of blood to 50mg for most drivers and 20mg for new and professional drivers, and may be in place by mid-2016. Given that alcohol remains a more significant issue than drugs in terms of road casualties, the priority has been to update drink drive legislation. The effects of the new drug driving legislation in England and Wales — and the progress of convictions before the courts under the new law — will be monitored before advancing any legislative change in this area.

⁴³ See: <http://gov.wales/docs/dhss/consultation/150715consultationen.pdf>

⁴⁴ List of illicit drugs and limits in the new legislation: benzoylecgonine (a cocaine metabolite), 50µg/L; cocaine, 10µg/L; cannabis, 2µg/L; ketamine, 20µg/L; LSD, 1µg/L; methylamphetamine, 10µg/L; MDMA, 10µg/L and heroin, 5µg/L.

⁴⁵ List of medicines and limits in the new legislation: clonazepam, 50µg/L; diazepam, 550µg/L; flunitrazepam, 300µg/L; lorazepam, 100µg/L; methadone, 500µg/L; morphine, 80µg/L; oxazepam, 300µg/L; and temazepam, 1,000µg/L.

⁴⁶ See: <http://www.niassembly.gov.uk/globalassets/Documents/RaISe/Publications/2014/general/7214.pdf>

Standardised packaging of tobacco

In January 2015 the Government announced that it would support the introduction of standardised packaging for tobacco products. In March, both Houses of Parliament approved the regulations. The policy will cover cigarettes and hand rolling tobacco, and is due to take effect on 20 May 2016 to coincide with the implementation of the revised EU Tobacco Products Directive (Official Journal of the European Union, 2014).

E-cigarettes

In the UK, from May 2016 all e-cigarettes and e-liquids will either meet the provisions of the *Tobacco Products Directive* (TPD) (40/2014/EU) or be licensed as a medicine or medicinal device by the Medicines and Healthcare Products Regulatory Agency (MHRA). In areas outside of the harmonised rules set out in the TPD the countries of the UK may, within the scope of their devolved powers, make their own policy on e-cigarettes.

England

On 1 October 2015 the *Nicotine Inhaling Products (Age of Sale and Proxy Purchasing) Regulations 2015* came into force in England and Wales, banning the sale of e-cigarettes to under-18s and the purchase of e-cigarettes by adults on their behalf. In August 2015, Public Health England (PHE) published a comprehensive independent review of the latest evidence on e-cigarettes. The expert review synthesises the international peer-PHE-reviewed evidence base on ecigarettes (Public Health England, 2015c). It provides a firm foundation for further policy development and public health practice in the context of the new regulatory regime for e-cigarettes. In spring 2016 PHE will publish non-binding guidance for employers and other authorities on the use of e-cigarettes in enclosed public places and workplaces, designed to maximise the health benefits while minimising the harm in any particular setting.

Wales

In June 2015 the Welsh Government announced their *Public Health (Wales) Bill*,⁴⁷ which details a series of specific proposals in priority areas of public health policy, including policies on tobacco and nicotine products.

The new tobacco and e-cigarette measures introduced by the Bill will:

- restrict use of e-cigarettes, banning them in enclosed public spaces and workplaces;
- require sellers to join a register for retailers of tobacco and e-cigarettes; and
- be an offence to “hand over” tobacco and e-cigarettes products to people under the age of 18

The Bill is expected to come into force in 2017.

Scotland

In June 2015, the Scottish Government introduced the *Health (Tobacco, Nicotine Etc. and Care) (Scotland) Bill*.⁴⁸ Alongside the Scottish Government's latest Tobacco Control Strategy, this Bill supports the Scottish Government's objective to support longer, healthier lives and to tackle the significant inequalities in Scottish society. It will do this in the main by restricting the accessibility of Nicotine Vapour Products to young people; reducing their visibility and appeal to young people and non-smokers; reinforcing the age restriction on tobacco products to further protect young people; and introducing statutory smoke-free perimeters around buildings on National Health Service (NHS) hospital sites.

⁴⁷ See: <http://www.assembly.wales/laid%20documents/pri-ld10224/pri-ld10224-e.pdf>

⁴⁸ See: http://www.scottish.parliament.uk/S4_Bills/Health%20Tobacco%20Nicotine%20etc.%20and%20Care%20Scotland%20Bill/b73s4-introd.pdf

Smoking in private vehicles carrying children.

In October 2015 a new law was introduced in England and Wales that prohibits smoking in private vehicles carrying passengers less than 18 years of age (Her Majesty's Government, 2015c).

Scotland

On 15 December 2014, Jim Hume, Member of the Scottish Parliament (MSP) and Liberal Democrat Spokesperson, introduced his Private Member's Bill on smoking in cars. The *Smoking Prohibition (Children in Motor Vehicles) (Scotland) Bill* proposes to prohibit adults from smoking in private vehicles in a public place where a person under the age of 18 is present in the vehicle.

Blanket ban on new psychoactive substances

The UK Government is proposing a Bill for a blanket ban of new psychoactive substances (NPS) in the UK, with the aim of prohibiting and disrupting the production, distribution, sale and supply of NPS in the country (see section 2.2.3).

4.3 Universal prevention

Universal prevention targets the entire population, regardless of individual levels of risk, with programmes, initiatives and messages aimed at preventing or delaying the onset of illicit drug use.

4.3.1 Schools and young people

England

Universal drug education is included in the national curriculum in England, where it is a statutory part of the science curriculum for schools and can be expanded through the non-statutory Personal, Social and Health Education (PSHE) programme (Department for Education, 2013).⁴⁹ In 2013, Ofsted⁵⁰ published a report evaluating the strengths and weaknesses of PSHE education in primary and secondary schools in England (Ofsted, 2013). The report concluded that in 40% of the schools examined, the PSHE curriculum required improvement or was inadequate, and many teachers did not have sufficient experience and training on drug education.

To address Ofsted's concerns and provide practical support and guidance to schools in 2014 the Alcohol and Drug Education and Prevention Information Service (ADEPIS) published a set of evidence-based quality standards covering the delivery of alcohol and drug education within the classroom (Alcohol and Drug Education and Prevention Information Services, 2014; UK Focal Point, 2014).

Alcohol and Drug Prevention Briefing Paper

As part of a series of briefing papers for alcohol and drug education and prevention for teachers and practitioners, Mentor ADEPIS has published a new document that looks at how building resilience in young people can prevent substance abuse. It also tries to define resilience and why it is important, explores the ways that these concepts can be translated into practice (giving evidence and examples) and what roles schools and other education settings have in building resilience.⁵¹

⁴⁹ The National Institute for Health and Care Excellence (NICE) provided evidence to the Department for Education for a review of PSHE. The evidence emphasised that effective programmes of alcohol and drug education contribute to reducing the risks associated with alcohol or drug use.

⁵⁰ Office for Standards in Education, Children's Services and Skills (Ofsted) is a non-ministerial department responsible to regulate and inspect services that care for children and young people, and services providing education and skills for learners of all ages.

⁵¹ See: <http://mentor-adepis.org/wp-content/uploads/2015/03/Building-resilience-and-character-in-young-people-ADEPIS.pdf>

Rise Above

In November 2014 PHE launched Rise Above, an interactive online resource where young people can find material aimed at encouraging them to talk about important issues in their life (UK Focal Point, 2014). This service was activated in February 2015. The website not only provides information but also supports a range of situational tools and skills-based resources. It aims to build young people's resilience and empower them to make positive choices for their health (including areas such as drugs, alcohol, smoking, body confidence, relationships and exam stress).

PHE has also developed its role in supporting local areas by sharing evidence to support commissioning and the delivery of effective public health prevention activities, and launching toolkits to support local areas' responses on specific issues around NPS and other drug groups.

Scotland

In Scotland, education has developed to encapsulate broader life-learning for children and young people through the Curriculum for Excellence⁵² where traditional education is integrated with wider life-learning for three to 18 year olds. In the Curriculum for Excellence, learning in health and well-being is designed to promote confidence, independent thinking and positive attitudes. This learning helps enable children and young people to become resilient to risk taking behaviours, and understand the wider impacts of staying safe and making positive choices

Choices For Life

The Scottish Government funds Choices For Life,⁵³ a diversionary and educational substance use initiative delivered by Police Scotland in partnership with Young Scot and Education Scotland. This tobacco, alcohol and drugs education programme for schoolchildren includes an information website for young people and their teachers, parents and carers. The newly revised Choices for Life website was fully integrated into the Young Scot website in May 2015. The digital aspect of the programme also uses social media platforms that young people are likely to use themselves including Twitter, YouTube, and a dedicated Choices for Life phone application.

The programme of work also includes a series of targeted community events delivered in conjunction with local partners to engage young people directly at the local level, interactive digital resources, and a summer festival safety campaign. The community events are aimed at local areas of need identified in each community, and are delivered via face-to-face events. Evaluation and feedback is sought from the events, and this learning is shared at a national level.

A short interactive film has been launched by Choices for Life to educate teenagers on the dangers of NPS and alcohol.⁵⁴ This new resource was produced in collaboration by Pace Media Productions, Police Scotland, Young Scot and the Scottish Government. The short film has an interactive element that allows the viewer to play the part of the main character and make decisions along the way, which will lead to further choices and an ultimate outcome. This increases the value of the film by offering the viewer the option to look at various outcomes of taking drugs, alcohol, or tobacco. Other issues can be drawn out, including parental relationships and sexual assault. These all help demonstrate that no single issue exists in a vacuum.

⁵² See: <http://www.educationscotland.gov.uk/thecurriculum/whatiscurriculumforexcellence/index.asp>

⁵³ See: <http://choicesforlifeonline.org/>

⁵⁴ See: <http://www.scotland.police.uk/whats-happening/news/2015/may/288264>

Wales

In Wales, in line with the goal laid out by the *Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-18* (Welsh Assembly Government, 2008a), the All Wales School Liaison Core Programme has been developed to deliver drugs education in primary and secondary schools.⁵⁵ In the last year, the *Steroids and Image Enhancing Drugs Educational Toolkit for young people (11-16 years)* has been developed and issued for all schools and youth groups across Wales.⁵⁶

Northern Ireland

The school curriculum places a specific focus on the development of relevant “life skills” among pupils. In particular, through Personal Development and Mutual Understanding (PDMU)⁵⁷ in primary schools, pupils are provided with opportunities to develop strategies and skills for keeping themselves healthy and safe. Post-primary school pupils, through Learning for Life and Work,⁵⁸ are provided with opportunities to investigate the effects on the body of legal and illicit substances and the risks and consequences of their misuse.

During the 2014/15 financial year the Council for Curriculum, Examinations and Assessment (CCEA) progressed work to update CCEA/Department of Education guidance on drugs and alcohol. The new guidance was published on the CCEA website in August 2015⁵⁹ and it is also available via the C2k information and communications technology (ICT) Managed Service and the Department of Education (DENI) website.⁶⁰

4.3.2 Family

England

The Early Intervention approaches are activities that are designed to influence a child's environment in early life, and prevent future adverse outcomes such as drug use. Programmes such as the Family Nurse Partnership⁶¹ have been introduced by the Government to help families create a healthy environment for their children. Early interventions are not directly targeted at drug use, but are part of a holistic approach, which recognises that broader social, health and behaviour approaches are needed for effective drug prevention programmes.

4.3.3 Community

Prevention of drug and alcohol dependence

In 2015 the ACMD Recovery Committee published a document aimed at supporting policy-makers and practitioners working in prevention as well as providing recommendations (Advisory Council on the Misuse of Drugs, 2015b). It outlines the evidence available for substance misuse prevention, and points out effective prevention interventions, recognising that there is still little clear evidence on ‘what works’ in drug prevention, but acknowledging that in recent years there has been an increase in the quality of evidence generated. The report outlines a number of promising approaches that are likely to be beneficial if correctly implemented. The paper concludes with a set of recommendations aimed at those working in the prevention field and authorities commissioning prevention programmes. The ACMD recommends that: practitioners should be encouraged to use a common language to help make

⁵⁵ The All Wales School Liaison Core Programme (AWSLCP) is jointly funded by the Welsh Government and the four Welsh police forces and targets pupils aged between five and 16. See: <https://www.schoolbeat.org/en/parents/know-the-programme/national-events/what-is-the-all-wales-school-liaison-core-programme/>

⁵⁶ See: <http://www.wales.nhs.uk/sitesplus/documents/888/SIEDS%20Toolkit%20English.pdf>

⁵⁷ See: http://ccea.org.uk/curriculum/key_stage_1_2/areas_learning/personal_development_mutual_understanding

⁵⁸ See: <http://www.rewardinglearning.org.uk/microsites/llw/>

⁵⁹ See: http://ccea.org.uk/curriculum/drugs_guidance

⁶⁰ See: <https://www.deni.gov.uk/articles/drugs-guidance#toc-1>

⁶¹ The Family Nurse Partnership provides support to young families (less than 19 years old) from pregnancy until the baby reaches two years of age, with structured home visits by trained nurses (see: <http://fnp.nhs.uk/>).

prevention strategies more coherent; authorities commissioning prevention programmes should see drug and substance use prevention as part of a more general strategy involving all aspects of clients' lives; an evaluation (including an economical evaluation) should be part of all UK prevention projects; and policy makers should acknowledge that prevention projects are justified on the basis of reducing long-term and meaningful adverse health and social outcomes even without drug abstinence.

Sources of support and information about drugs

There are several universal prevention communication programmes in the UK.

England

- 'Talk to FRANK'.⁶² The FRANK campaign was launched in 2003 jointly funded by the Home Office and Department of Health, and supported by PHE. It provides information about drugs to young people (under 16s) and their families, as well as a 24 hour information and helpline service operated by fully trained advisers. The service can be accessed through a number of channels including the helpline, the FRANK website, SMS, email and the FRANK BOT (an interactive service delivered via MSN messenger).
- PHE launched a new online resilience building resource 'Rise Above'; which is aimed at 11-16 year-olds and provides resources to help develop their skills to make positive choices for their health and well-being, including resisting drug use (see section 4.3.1).

Scotland

- 'Know the Score'⁶³ provides factual information and advice to young people, their families and professionals. It is supported by the Scottish Government and provides a 24 hour online information service, and a telephone helpline on drugs information and advice from 8am to 11pm, 7 days a week.
- The Scottish Government provides a significant package of funding to its main commissioned organisations that contribute to the delivery of the drug strategy, *The Road to Recovery* (Scottish Government, 2008c).
- The Scottish Government funds the 'Choices for Life' schools-based substance misuse education programme, delivered in partnership with Young Scot and Police Scotland. This drugs, alcohol and tobacco education programme for school children, includes an information website for young people and their parents, teachers and carers, as well as a series of community events to engage young people directly and provide credible information to help them make the right health choices.

Northern Ireland

- In Northern Ireland, the Public Health Agency⁶⁴ develops public information campaigns for various target groups and settings. In addition, Northern Ireland contributes to the telephone helpline element of the FRANK campaign.

Wales

- 'Dan 24/7'⁶⁵ is a bilingual (Welsh and English) 24 hour information and telephone helpline service, which frequently runs targeted campaigns. It is hosted by the Betsi Cadwaladr University Health Board with funding provided by the Welsh Government. The helpline is aimed at assisting individuals, their families, carers, and support workers within the drug and alcohol field to access appropriate local and regional services.

⁶² See: <http://www.talktofrank.com/>

⁶³ See: <http://knowthescore.info/>

⁶⁴ See: <http://www.publichealth.hscni.net/>

⁶⁵ See: <http://www.dan247.org.uk>

4.4 Selective prevention in at-risk groups and settings

Selective prevention initiatives target subsets of the total population that are deemed to be at greater risk of substance misuse or risky behaviour such as truants or young offenders.

4.4.1 Young people

Substance misuse services for young people

Specialist substance misuse treatment for young people is recognised as a form of prevention in the UK, as it aims to stop drug and alcohol use escalating, to reduce harm to young people or others, and to prevent them becoming drug or alcohol-dependent adults. The Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS) showed that in 2013/14 19,126 young people (under 18 years) accessed specialist substance misuse services, with the majority having presented with cannabis (71%) or alcohol (20%) as their primary problem substance (Public Health England, 2014g).

Young people with multiple vulnerabilities

Young people presenting to specialist substance misuse services frequently have multiple vulnerability factors such as being a looked after child, having a history of self-harm or offending behaviour. The Young People's Statistics from NDTMS identify 10 of these vulnerability factors.⁶⁶ Of the 7,965 new presentations in 2013/14, 59% had two or more of these vulnerability factors (Public Health England, 2014g).

Northern Ireland

A range of specialist services are commissioned for children and young people in Northern Ireland. The Drug Treatment Database shows that in 2013/14 175 under 18s were in treatment for drug misuse in Northern Ireland – around seven per cent of all those in treatment (Department of Health, Social Services and Public Safety Northern Ireland, 2015).

New Psychoactive Substances (NPS) Resource pack for informal educators and practitioners

A group of experienced practitioners from Mentor UK, DrugScope, local youth and drug treatment services and Youth Offending Teams have developed for the Home Office a resource pack for formal and informal educators who work with young people in specialist and targeted services such as youth services, drug treatment services or youth offending teams.⁶⁷ This pack aims to provide information on the current knowledge around NPS, interventions available and approaches that will support them to respond to the risks that these substances can play in the lives of young people. Even though this resource is targeted at NPS, the information provided can be similarly applied to all drug taking behaviour, and discussion about NPS should form part of a broader conversation about drug use in general.

⁶⁶ The 10 vulnerability factors are: a young person

- began using primary substance aged under 15;
- reports involvement in offending behaviour;
- reports self-harming;
- is a looked after child (LAC);
- reports using opioids and/or crack;
- is not in education or employment;
- reports unsettled accommodation status or has no fixed abode (NFA);
- reports using two or more drugs in combination (polydrug use);
- is pregnant or a parent; and
- reports almost daily drinking or drinking in excess of eight units (males) or six units (females) on an average drinking day when drinking 13 or more days of the month

⁶⁷ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412168/150311_Psychoactive-drugs11-colour_18-33-44_-_1_.pdf

4.4.2 At-risk families

Troubled families

The first Troubled Families Programme was launched in 2012 and aimed to turn around the lives of 120,000 troubled families across England by May 2015. Delivery of the Troubled Families programme was unprecedented for an initiative of its kind in the UK in terms of the scale and pace required. Families taken on to the programme have multiple problems: children not in school; children committing crime; anti-social behaviour; parents not working; and other high cost problems, such as drug abuse and domestic violence. As well as the cost to family members themselves, these families place a substantial burden on the public purse. It was estimated that £9 billion every year was being spent on services for troubled families, with £8 billion of that money being spent just reacting to their problems (Communities and Local Government, 2012). Despite this expenditure, services may struggle to get to the root of the families' problems if they are only seeing individual family members and their problems in isolation. The Troubled Families Programme advocates key workers working with the whole family tackling all of their problems, with services working together in the best interests of the whole family (UK Focal Point, 2012, 2013).

In 2013 the Government announced an expansion of the Troubled Families programme to reach up to an additional 400,000 families from 2015/16. The new programme retains the focus on families with multiple high cost problems and continues to include families affected by poor school attendance, youth crime, anti-social behaviour and unemployment. It also seeks to reach out to families with a broader range of problems including children in need, adults facing financial exclusion or young people at risk of worklessness, families affected by domestic violence and abuse, and parents or children with a range of health problems. LAs can claim results' payments for families in their local programme when they can demonstrate that a parent has moved into continuous employment or that significant and sustained progress across all the families' problems has been achieved. This will be assessed against locally set outcome measures. The broadening of the eligibility criteria and the ability for local areas to determine their own outcomes measures provides greater flexibility to LAs, enabling them to tailor the programme to meet local needs. The programme promotes the integration of local public services around the needs of families. It has a strong focus on service transformation, incentivising local public services to reduce demand on costly reactive services for the long term (e.g. reducing child protection levels, police call outs and Accident and Emergency pressures).

Family Drug and Alcohol Court

Family Drug and Alcohol Courts (FDACs) are specialised courts designed to work with parents who abuse substances and are involved with the child welfare system. They aim to improve children's outcomes by addressing their parents' difficulties, and parents and children are able to remain together safely during the court proceeding. The courts are able to make quick alternative placement decisions for the child if parents are unable to successfully address their substance misuse problems. They have been adapted to the English legal system from a model of Family Treatment Drug Courts (FTDCs) which has been widely used in the USA (Worcel, Furrer, Green, Burrus, & Finigan, 2008). Key differences between FDAC and standard care proceedings are that a dedicated judge will usually preside over all hearings in a given case and families are supported by a multi-disciplinary specialist support team, which reports back to the judge on progress. There are FDACs in London, Gloucestershire, Milton Keynes and Buckinghamshire. In February 2015, the then coalition government announced that they supported the expansion of FDACs to new areas across the country (Whitehead, 2014).

4.4.3 Other at-risk groups

The Mental Health Taskforce

The Mental Health Taskforce was formed in March 2015, and is constituted of health and care leaders and experts in the field plus service users. Its aim is to develop a five year national strategy for mental health, covering services for all ages.

The strategy will include: prevention; first contact with services; diagnosis; treatment; optimising quality of life; and support for those living with complex and long term mental health conditions (including dementia) as well as addressing equality and human rights issues related to mental health. The strategy will also include recommendations on the mechanisms and data required for its implementation and on how to monitor the delivery of its outcomes (ensuring that priorities, costs and benefits within the strategy are assessed).⁶⁸

⁶⁸ See: <http://www.england.nhs.uk/mentalhealth/taskforce/>

5. Drug-related treatment: treatment demand and availability

5.1 Introduction

United Kingdom (UK) drug strategies identify treatment as being effective in tackling problem drug use and seek to improve its quality and effectiveness. *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (Department of Health England and the devolved administrations, 2007) continues to provide guidance for clinicians delivering drug treatment in the UK, although updated guidelines are currently in development. The National Institute for Health and Care Excellence (NICE)⁶⁹ also provides guidance on a number of drug-treatment related topics, and these are reviewed and updated regularly based on the latest evidence. Co-ordination and integration across a range of service providers is seen as key in helping problem drug users reintegrate into society, and all recent UK drug strategies focus on this area. While providing treatment remains a priority, housing, employment, education and training have also been identified as important, with the most recent drug strategies having a much stronger focus on recovery and reintegration.

Treatment interventions in any given area are expected to include advice and information, care planning, psychosocial interventions, community prescribing, inpatient drug treatment and residential rehabilitation. In addition, drug misusers should be offered relapse-prevention and aftercare programmes; hepatitis B vaccinations; testing for hepatitis B and C and HIV; access to hepatitis and HIV treatment; and needle exchange. Oral opioid substitution treatment (OST) with methadone is the most common pharmacological treatment used in treating heroin addiction. Buprenorphine can also be prescribed, and injectable opioids, such as injectable methadone and injectable diamorphine, are also available but are not commonly used. Naltrexone⁷⁰ is recommended as a treatment option to prevent relapse in detoxified formerly opioid-dependent people who are highly motivated to remain in an abstinence-based programme.

Treatment Demand Indicator (TDI) data on numbers presenting to treatment are from four separate systems: the National Drug Treatment Monitoring System (NDTMS) in England; the Scottish Drug Misuse Database (SDMD); the Welsh National Database for Substance Misuse (WNDSM); and the Northern Ireland Drug Misuse Database (NIDMD). Data from the four systems are combined into UK totals for reporting to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Continuous national data are available from 2003/04.

5.2 Policy, strategy and quality assurance

5.2.1 Strategy and policy

Main treatment priorities in the national drug strategy

The UK *Drug Strategy, Reducing demand, restricting supply, building recovery: supporting people to live a drug free life* (Her Majesty's Government, 2010) emphasises supporting those who are drug dependent to achieve recovery, and the provision of the integrated support necessary to enable this (see section 1.2.1).

The 'building recovery' strand of the strategy includes a number of objectives relating to treatment. These include:

- ensuring that all those on a substitute prescription engage in recovery activities;
- supporting services to work with individuals to draw on a client's "recovery capital";

⁶⁹ Formerly the National Institute for Health and Clinical Excellence.

⁷⁰ A drug that blocks the effects of opioids and alcohol.

- commissioning drug treatment and recovery services which are locally led, transparent about performance and delivered in line with best practice;
- launching Public Health England (PHE) whose role is to support local authorities (LAs) on commissioning services most suitable for their area and population;
- encouraging local areas to jointly commission services to deliver “end to end” support;
- enabling people to successfully reintegrate into their communities following treatment by tackling housing needs and helping them find sustained employment; and
- launching six Payment by Results (PbR) pilots to investigate affordability and value for money in drugs recovery for adults

Progress has been made towards each of these objectives and new priorities were cited in the 2015 annual review of the drug strategy. These include:

- evaluation of the PbR pilots;
- amend medicines regulations to allow for the wider distribution of naloxone (see section 2.2.1); and
- implement a new drug appointment licence condition that can require prisoners to attend appointments at treatment services in the community upon release (see section 8.7.3)

Public Health Outcomes Framework England

The Public Health Outcomes Framework (PHOF)⁷¹ (Department of Health, 2012) sets out the Secretary of State’s strategic direction in meeting two high level objectives:

- to increase healthy life expectancy; and
- to reduce differences in life expectancy and healthy life expectancy between communities

This includes indicators which are explicitly related to drugs; the main one being successful completion of treatment for opioid and non-opioid users who do not return within six months.

Scotland

The concept of recovery and supporting people to live a drug-free life as active and engaged members of society is central to the Scottish Government’s drug strategy, *The Road to Recovery: A new approach to tackling Scotland’s drug problem* (Scottish Government, 2008c) (see section 1.2.1).

The key treatment-related priorities of the strategy are:

- to see more people recover from problem drug use so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy; and
- improving the effectiveness of delivery at a national and local level

The Scottish Government has developed a Recovery Outcomes Web (ROW) tool for use by local services to record and monitor people affected by problem drug and alcohol use. This is an independently validated, peer-reviewed tool which has been developed through consultation with Alcohol and Drug Partnerships (ADPs), drug and alcohol frontline staff, managers, service users and research groups.

⁷¹ See: <http://www.phoutcomes.info/>

The key aim of the tool is to measure changes in a person's life as a result of an intervention received when they access specialist support from drug and/or alcohol services in Scotland. This tool will help to provide a better understanding of an individual's recovery journey, related needs and motivation for change. Secondary benefits of the outcomes measurement tool are to inform workforce development, service improvement and future service provision for managers, ADPs, funding bodies and the Scottish Government. The ROW tool will be built into Scotland's new integrated Drug and Alcohol Information System (DAISy) which is expected to go live in autumn 2016.

Wales

The Welsh Government's drug strategy, *Working together to reduce harms 2008-2018* (Welsh Assembly Government, 2008a) predominantly focuses on reducing the harms associated with substance misuse (see section 1.2.1). Their treatment-related objectives include:

- improving the availability of treatment services and related support;
- making better use of resources — utilising evidence based decision making, improving treatment outcomes and developing the skills of those working in the treatment sector and promoting joined up working across agencies; and
- developing user-focused services

The strategy has been accompanied by shorter term implementation plans which outline performance measures for each of the key action areas, including supporting substance misusers to improve their health and to aid and maintain recovery.

A Recovery Framework was launched in February 2014,⁷² which is supported by the Recovery Group for Wales. Two courses have been designed by partner organisations in the Recovery Group for Wales to facilitate this process, namely: *Embracing Recovery* and *Recovery Framework: Theory to Practice*. The main priority of the Recovery Group for Wales is to ensure the principles of the framework are embedded throughout Wales. Establishing recovery-oriented systems of care; peer-led recovery community support; and implementing best practice across Wales continue to be prioritised.

Northern Ireland

The current Northern Ireland (NI) strategy, *New Strategic Direction for Alcohol and Drugs (NSD) Phase 2, 2011-2016* (Department of Health Social Services and Public Safety Northern Ireland, 2011b) has a number of treatment-related priorities including:

- developing a regional commissioning framework for treatment;
- targeting those at risk and vulnerable; and
- workforce development

5.2.2 Quality Standards

The Care Quality Commission

The Care Quality Commission (CQC) is an independent body charged with monitoring, inspecting and regulating health and social care services in England. In July 2015 the CQC launched an inspection handbook for service providers.⁷³ This was developed after a series of pilots conducted in early 2015 and details how inspections will be planned and arranged, what evidence will be gathered and through what means, and how services will be judged and rated, as well as the potential outcomes, including the consequences and enforcements for those rated 'requires improvement' or 'inadequate'.

⁷² See: <http://gov.wales/topics/people-and-communities/communities/safety/substancemisuse/policy/treatmentframework/?lang=en>

⁷³ See: <http://www.cqc.org.uk/content/provider-handbooks?page=1>

Local Delivery Plans

The Local Delivery Plan (LDP) Standard (formerly Health Improvement, Efficiency and Access Treatment (HEAT) Standard) for drug and alcohol treatment waiting times expects that 90% of people receive access to appropriate drug and/or alcohol treatment within three weeks of referral to support their recovery (Information Services Division, 2015a). Getting people into treatment quickly for drug-related problems is a priority for the Scottish Government, as evidence suggests this is likely to result in improved client outcomes. The HEAT Standard was initially introduced as a target and had been exceeded by March 2013. It then became a HEAT Standard for 2013/14 and beyond.

Data is published on a quarterly basis at national, Health Board and ADP level. The most recent statistics, published in June 2015, indicate that in January – March 2015, 95% of the 11,114 people who started their first drug or alcohol treatment waited three weeks or less (LDP Standard) (Scottish Government, 2015a). This ambitious Standard therefore continues to be exceeded at national level.

For drug treatment, 94.1% of the 4,136 people who attended an appointment for drug treatment between January and March 2015 waited three weeks or less, a slight increase from 93.7% in the previous quarter.

For alcohol treatment, 95.5% of the 6,978 people who started alcohol treatment between January and March 2015 waited three weeks or less, a slight decrease from 95.7% in the previous quarter.

5.2.3 Guidelines for treatment

In September 2007 the *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (Department of Health England and the devolved administrations, 2007) were published, to be used as a guide by all clinicians working in drug misuse treatment, particularly those providing pharmacological interventions.

The guidelines include the following key principles underlying appropriate care of drug misusers:

- drug misusers have the same entitlement as other patients to the services provided by the National Health Service (NHS);
- the General Medical Council's statement that: *"The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs"*;
- it is the responsibility of general practitioners to provide general medical services for drug misusers. Health Authorities, Primary Care Trusts in England, local health boards in Wales and health boards in NI and Scotland all have a duty to provide treatment for drug misusers, to meet local population needs. This should include interventions to reduce drug-related harm, such as hepatitis B vaccinations and needle exchange provision, together with evidence-based drug treatment;
- every doctor must provide medical care to a standard which could reasonably be expected of a clinician in his or her position. An increasing number of clinicians are trained and supported to provide drug treatment under the terms of a contract negotiated with their local commissioners; and
- the focus for the clinician treating a drug misuser is on patients themselves. However, the impact of their drug misuse on other individuals and on communities should be taken into consideration.

In 2014 PHE, on behalf of the departments of health in England, Scotland, Wales and Northern Ireland, held a consultation regarding whether these guidelines could benefit from being updated, despite much

of the content remaining current.⁷⁴ The majority of responses received to the consultation, through focus groups and in writing, were in favour of an update, and consequently a review of the evidence is currently being conducted. Updated guidelines are expected to be published in early 2016.

NICE have produced a range of guidelines, technical appraisals and pathways relating to best practice and standards of care in the treatment of substance misuse. Interventional procedures apply to all countries of the UK. Clinical guidelines and technology appraisals apply to those using the NHS in England and Wales only and are usually disseminated after local review in Northern Ireland. Public health guidance applies to those using the NHS in England only and is often disseminated after local review in other UK countries.⁷⁵

The key NICE guidelines⁷⁶ relating to substance misuse treatment are:

- CG51 (2007) Drug misuse — psychosocial interventions (National Institute for Health and Care Excellence, 2007b);
- CG52 (2007) Drug misuse — opioid detoxification (National Institute for Health and Care Excellence, 2007a);
- CG120 (2011) Psychosis with coexisting substance misuse: Assessment and management in adults and young people (National Institute for Health and Care Excellence, 2011);
- PH4 (2007): Interventions to reduce substance misuse among vulnerable young people (National Institute for Health and Care Excellence, 2007c);
- PH52 (2014): Needles and syringe programmes (National Institute for Health and Care Excellence, 2014b);
- PH49 (2014) Behaviour change: individual approaches (National Institute for Health and Care Excellence, 2014a);
- QS23 (2012) Drug use disorders (National Institute for Health and Care Excellence, 2012); and
- TA114 (2007) Methadone and buprenorphine for the management of opioid dependence (National Institute for Health and Care Excellence, 2007d)

Turning Evidence into Practice

Throughout 2014 and 2015 PHE has issued a series of briefings entitled *Turning Evidence into Practice*,⁷⁷ which provide advice to commissioners and services on a range of topics including:

- helping service users to access and engage with mutual aid;
- helping service users to engage with treatment and stay the course;
- biological testing in drug and alcohol treatment;
- optimising OST;
- preventing drug-related deaths;
- improving hepatitis C treatment; and
- image and performance enhancing drugs

⁷⁴ See: <https://www.gov.uk/government/consultations/drug-misuse-and-dependence-uk-guidelines-on-clinical-management>

⁷⁵ See: <https://www.nice.org.uk/about/what-we-do>

⁷⁶ See: www.nice.org.uk

⁷⁷ See: <http://www.nta.nhs.uk/2015.aspx>

All of these briefings are drawn from published evidence, guidance and expert consensus and provide both an overview of the topic as well as prompts for commissioning effective services.

Project NEPTUNE

The Novel Psychoactive Treatment UK Network (NEPTUNE),⁷⁸ an independent charity funded by the Health Foundation, conducted a systematic review of the evidence on club drugs,⁷⁹ focusing particularly on their acute and long-term harms and convened a group of UK experts to provide clinical consensus on their treatment. This evidence was then used to develop *Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances* (Abdulrahim & Bowden-Jones, 2015), which was published in March 2015.⁸⁰

The guidance is aimed specifically at clinicians in specialist drug treatment services, hospital emergency departments, general practice/primary care and sexual health clinics. It is designed to increase the confidence and skills of clinicians in the detection and identification of club drugs and new psychoactive substances (NPS).

New psychoactive substances toolkit

In November 2014, PHE published a toolkit⁸¹ to help LAs and NHS England respond to NPS use and associated problems in their area. The toolkit provided advice, resources and points for consideration across multiple factors including tackling supply and use, prevention, NPS interventions and treatment, NPS in prisons and competence in working with NPS users.

5.2.4 Evaluations and reviews

Advisory Council on the Misuse of Drugs review of opioid substitution therapy

In 2014 the Inter-Ministerial Group on Drugs commissioned the Advisory Council on the Misuse of Drugs (ACMD) to investigate:

- whether or not evidence supported the case for time limiting OST;
- if so what would a suitable time period be and what would be the risks and the benefits; and
- if time limiting OST is not supported, how can OST be optimised to maximise recovery outcomes for service users

The ACMD produced two reports in response to the commission. The first, published in November 2014 (Advisory Council on the Misuse of Drugs, 2015a), concluded that time limiting OST could result in:

- the majority of clients relapsing in to heroin use; and
- significant unintended consequences such as increases in drug-driven crime, heroin overdose deaths and spread of blood-borne viruses (BBVs)

It is also possible that such a restriction could be subject to medico-legal challenges.

The second paper, published in October 2015, made six recommendations for how OST can be optimised. These are:

⁷⁸ See: <http://neptune-clinical-guidance.co.uk/>

⁷⁹ The term 'club drugs' is used here to refer to a group of psychoactive substances typically used in dance venues, house parties, music festivals and sometimes in a sexual context

⁸⁰ See: <http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf>

⁸¹ See: <http://www.nta.nhs.uk/uploads/nps-a-toolkit-for-substance-misuse-commissioners.pdf>

- the Government and LAs should protect the investment in recovery-oriented drug treatment and recovery systems;
- LAs should strive for a culture of stability and quality improvement in drug treatment;
- the Government should implement a national quality improvement programme for recovery-oriented OST and ensure implementation of evidence-based practice;
- LAs should ensure all local drug treatment and recovery systems have enough community and residential abstinence pathways and ongoing recovery support;
- discrimination and stigmatising of those in medication assisted recovery should be tackled at all levels; and
- further research should be undertaken to build the UK research evidence on recovery-oriented treatment and interventions for heroin users

5.3 Organisation and provision of drug treatment

5.3.1 Outpatient drug treatment system

Main providers

In the UK, community-based specialised drug treatment centres are the most common providers of substance misuse services. Specialist services account for 89% of community-based treatment units reporting to the NDTMS in England ($n = 906$). General Practitioners (GPs) prescribing OST medications in a shared care arrangement report to NDTMS through the specialist service providing the shared care component. Some GPs prescribing in isolation do not report to NDTMS, so there is some under reporting. As such, the number of 'General/Mental health care' services is underreported in ST24.

Specialised drug treatment centres are predominantly public services, commissioned and funded by local government. The contracts to deliver drug treatment services commissioned by LAs are often held by third sector organisations (i.e. registered charities). Some of these organisations (such as Addaction⁸²) specialise solely in substance misuse, whilst others (for example, Turning Point⁸³) deliver contracts for Mental Health services and services for people with learning disabilities. Specialist drug treatment services are also provided in the NHS by Mental Health Trusts.

Low-threshold agencies

TDI data is not supplied for low-threshold services in the UK. However, there are various services providing such interventions including Criminal Justice Intervention Teams (CJITs) and Liaison and Diversion services⁸⁴ (see sections 2.4.2 and 2.4.3 respectively); needle and syringe programmes (NSP) (see section 6.6.1); and information, advice and harms reduction services.

Prisons

There are 141 prisons across the UK (123 in England and Wales, 15 in Scotland and three in Northern Ireland). The majority of prisons offer some form of treatment for substance misuse. However, prison drug treatment reporting is not yet fully integrated with community datasets and, at present, only NI prison treatment data is included in TDI figures. The 2014/15 Her Majesty's Inspector of Prisons survey reported that 28% of male and 41% of female new arrivals at prison stated they had substance misuse needs (Her Majesty's Inspectorate of Prisons, 2015). The provision of treatment in prisons is covered in section 8.5.2.

⁸² See: <http://www.addaction.org.uk/>

⁸³ See: <http://www.turning-point.co.uk/>

⁸⁴ See: <http://www.england.nhs.uk/wp-content/uploads/2014/04/ld-op-mod-1314.pdf>

Almost all clients treated in the UK receive treatment in a community setting, including some who receive treatment in the community before or after attending a residential unit. The treatment system in the UK was greatly expanded during the early 2000s in order to address the demand for services following the heroin epidemic of the 1990s. The majority of clients accessing the treatment system in the UK (both outpatient and inpatient) cite heroin as a problematic drug (see ST34). Comparisons with Problem Drug Use estimates suggest that in England around 56%⁸⁵ of the problem opioid and/or crack using population access community treatment services. Other commonly cited substances include cannabis and cocaine.

5.3.2 Inpatient drug treatment system

Main providers

Inpatient and residential facilities account for 11% of all substance misuse treatment units in England.

Inpatient units provide assessment, stabilisation and/or assisted withdrawal with 24-hour cover from a multidisciplinary clinical team who have had specialist training in managing addictive behaviours. In addition, the clinical lead in such a service comes from a consultant in addiction psychiatry or another substance misuse medical specialist. The multi-disciplinary team may include psychologists, nurses, occupational therapists, pharmacists and social workers. Inpatient units are for those alcohol or drug users whose needs require supervision in a controlled medical environment. These units are often based within hospitals but can also be attached to residential rehabilitation services, or may be standalone. Inpatient detoxification interventions may also be delivered on a general ward within a hospital.

Residential rehabilitation services are primarily run by voluntary and private sector organisations. They offer structured programmes that may include psychosocial interventions, individual and group therapy, education and training, and social and domestic skills. There is a broad range of different types of residential rehabilitation available, and services differ widely in terms of their philosophy, intensity, inclusion criteria, programme content and duration.

In early 2014, PHE conducted a survey of both providers of residential rehabilitation and substance misuse commissioners in England, in part to assess the impact of changes to the commissioning structure that occurred in April 2013 (Public Health England, 2014d). Nearly three quarters (70%) of providers stated that adult social care was their largest funding source. Other sources of funding reported by providers included the public health grant (42%), local authority supporting people funding (20%) and private clients (50%).

The commissioning of inpatient services in NI was reviewed and revised in 2014 and the new regionally networked and managed system has been embedded during 2015.

Another non-hospital based residential setting in the UK is a recovery house. A recovery house is a residential living environment, in which integrated peer support and/or integrated recovery support interventions are provided for residents who were previously, or are currently, engaged in treatment to overcome their drug and alcohol dependence. The residences are also referred to as dry-houses, third-stage accommodation or quasi-residential.

⁸⁵ Based on latest available estimates for prevalence of opioid use and/or crack cocaine use: 293,879 from 2011/12 (Hay et al., 2014)

The proportion of the overall treatment population who receive treatment in inpatient/residential settings is low compared to those who receive it on an outpatient basis. In England, 1.6% of the total treatment population were reported as having been treated in an inpatient unit and 1.3% in a residential service or recovery house (with some clients having been treated in both). It should be noted that residential services in England are not required to report treatment information on private clients to NDTMS, and as a result the number of clients treated in residential settings is underreported in TDI and other treatment statistics.

The average cost of inpatient treatment is £158.36 daily compared with £99.57 for residential rehabilitation.⁸⁶ Given that the average time spent in residential rehabilitation is 13 weeks, this equates to an average of £9,000 for every treatment episode commissioned by local authorities. As such, clients accessing rehabilitation will usually be required to meet certain admission criteria including:

- being abstinent from drugs and alcohol following detoxification;
- a commitment to becoming substance free;
- a desire to leave treatment; and
- having been assessed as capable of achieving abstinence and prepared to do so

Clients are usually also required to complete a period of community treatment prior to rehabilitation and may return to community services for further support after exiting inpatient facilities.

The NICE clinical guideline CG51 (2007)⁸⁷ recommended that residential rehabilitation be used for the “most complex users”. As such, clients accessing residential rehabilitation will usually have:

- not benefited from previous community-based psychosocial treatment;
- longer and more entrenched drug and alcohol misusing careers;
- a range of problem substances;
- more significant housing problems; and
- co-morbid physical and/or mental health problems

In addition, residential rehabilitations treat a higher proportion of clients who are:

- using both heroin and crack;
- injecting drugs;
- polydrug users; and
- offenders

In 2013/14 in England 3,935 clients accessed support through residential rehabilitation, as reported by the NDTMS (Public Health England, 2014d). Clients in residential rehabilitation consistently made up about two per cent of all those reported as being in drug treatment.

⁸⁶ Based on the New Economy Unit Cost Database, see: http://neweconomymanchester.com/stories/832-unit_cost_database

⁸⁷ See: <https://www.nice.org.uk/guidance/cg51/chapter/1-Guidance>

5.4 Access to treatment

5.4.1 Changes to the Treatment Demand Indicator and reporting

The TDI records the number of clients presenting to a treatment centre in a particular year, but does not provide information on clients who remain in treatment without starting a new treatment episode.⁸⁸ Data presented are from the NDTMS in England, the SDMD in Scotland, the WNDSM⁸⁹ in Wales and the NIDMD in Northern Ireland. Data are presented for the UK as a whole unless otherwise stated.⁹⁰ Continuous national data are available from 2003/04.

From the reporting year 2014, the UK has changed the period it reports from financial to calendar year primarily to align with other European Union (EU) member states⁹¹, and the TDI methodology underwent significant change.⁹² Due to changes in the TDI protocol, data for 2013 and 2014 calendar years are not directly comparable to previous national reports.

In 2014, 100,456 clients presented to treatment in the UK.⁹³ Similarly to previous years, 76.3% were male and 35.5% had never received treatment previously.

5.4.2 Treatment centres

A total of 1,104 treatment centres reported through national treatment monitoring systems in the UK during 2014. Of these, 81% provided outpatient services ($n = 894$), 10.5% provided inpatient services ($n = 116$) and 6.3% were general practitioner (GP) services ($n = 70$).

Table 5.1 shows that 86% of all clients presenting to drug treatment in the UK during 2014 were treated in outpatient centres. Opioid users make up a larger proportion of clients within inpatient and GP services than within outpatient services.

5.4.3 Characteristics of treated clients

The following data outlines the characteristics of clients seeking treatment in the UK and is based on data from ST34 and TDI.

Source of referral

As in previous years, the most common source of referral amongst clients starting a new episode of treatment in 2014 was self-referral (40.0%), with referral from the criminal justice system (CJS) the next most common referral source (26.3%). Despite the association between opioid use and crime, the proportion of opioid clients referred to treatment through the CJS was about the same as the proportion of cannabis users (27.9% and 26.3% respectively).

Those presenting to treatment for the first time were more likely to have been referred by a GP than those previously receiving treatment (9.3% and 6.3% respectively). Those who had previously received treatment were more likely to have a criminal justice referral than first ever treatments (28.7% and 22.2% respectively).

⁸⁸ See: <http://www.emcdda.europa.eu/html.cfm/index65315EN.html>

⁸⁹ Data from Wales include less structured treatments

⁹⁰ Percentages quoted are valid percentages

⁹¹ Northern Ireland and Scotland continue to report financial year

⁹² See: <http://www.emcdda.europa.eu/publications/manuals/tidi-protocol-3.0>

⁹³ Excluding Greater Glasgow and Clyde and Tayside

Table 5.1: Primary drug by centre type in the United Kingdom, 2014

DRUG	OUTPATIENTS		INPATIENTS		GP*		OTHER		TOTAL	
	n	%	n	%	n	%	n	%	n	%
Amphetamines	2,509	2.9	31	2.2	30	1.5	1	0.08	2,673	2.8
Benzodiazepines	1,164	1.3	45	3.2	123	6.0	231	18.3	2,102	2.2
Cannabis	23,260	26.9	64	4.6	133	6.5	598	47.5	25,278	26.0
Cocaine†	8,521	9.9	110	7.9	58	2.8	154	12.2	9,154	9.4
Crack cocaine	2,865	3.3	118	8.5	53	2.6	0	0	3,082	3.2
Opioids	44,439	51.4	984	70.5	1,553	75.9	262	20.8	50,592	52.1
Other	3,715	4.3	44	3.2	95	4.6	14	1.1	4,187	4.3
Sub Total	86,473	100	1,396	100	2,045	100	1,260	100	97,068	100
Not Known	154		5		5		0		3,388	
Total	86,627	86.2	1,401	1.4	2,050	2.0	1,260	1.3	100,456	100

*data are for England only

†includes cocaine powder and cocaine unspecified

Source: ST34

Primary drugs used

In 2014, around half of all treatment presentations in the UK were for primary opioid use (52.1%), with just over one quarter (26.0%) for primary cannabis use. However, the pattern is markedly different between those who report that they have been previously treated and those who do not, with cannabis being the most frequently reported primary drug amongst first ever presentations (46.6% compared to 14.8% of those reporting previous treatment). Almost one-quarter (23.2%) of new treatment presentations reported primary opioid use, compared to over two-thirds (68.0%) of previously treated clients. This is indicative of heroin clients being more likely to drop out of treatment and to subsequently re-present, or to relapse after completing a treatment episode and to seek treatment again as a result.

In 2013/14 in England 79% of clients in contact with treatment services were using opioids, a substantially higher proportion than the 52.1% of treatment entrants who cited this. This difference in proportions is largely due to opioid clients typically spending longer in treatment than those presenting with other drugs.

Conversely, cannabis clients accounted for just nine per cent of clients in treatment in England in 2013/14 but 26% of treatment entrants. This is explained by the relatively short time cannabis clients spend in treatment, leading to a higher turnover of clients when compared to those accessing support for opioid use.

Whilst new treatment entrants were more than twice as likely to report a primary substance of powder cocaine when compared to previously treated clients (13.7% and 6.4% respectively), they were less likely to report a primary substance of crack cocaine (2.2% and 3.8% respectively) indicating that crack users are also more likely to have multiple episodes. First time treatment entrants were also more likely to report the primary use of stimulants other than cocaine (7.2%), and benzodiazepines (2.9%), compared to those who had been previously treated (3.9% and 1.7% respectively).

Secondary substances

Crack cocaine

The number of primary heroin clients entering treatment reporting secondary use of crack cocaine has been increasing since 2003/04, and in 2014 accounted for 41.1% of all primary heroin presentations (a rise from 37.9% in 2013). In 2013/14 almost one-third (32%) of clients in treatment in England were opioid and crack users (Public Health England, 2014a).

Alcohol

Primary powder cocaine clients were most likely to report secondary alcohol problems (40.2% of all clients). Other frequent secondary citations of alcohol occurred alongside cannabis (30.9%) and crack cocaine (30.6%). Overall, 21.7% of all clients presenting to treatment in 2014 reported a secondary alcohol problem.

The proportion of primary heroin presentations reporting a problem with alcohol increased from 8.9% in 2007/08 to 15.6% in 2013 where it has remained stable, accounting for 15.5% in 2014. It is uncertain if this reflects an increase in prevalence of alcohol problems amongst this group or whether it is due to an increased awareness of the importance of alcohol issues amongst treatment providers and a change in recording practices. Given the prevalence of secondary alcohol problems amongst the general treatment population, and that research evidence that suggests higher levels of alcohol problems amongst methadone users than the treatment data suggests (33%) (Sebanjo, Wolff, & Marshall, 2007), alcohol problems may be under-reported amongst this group.

Benzodiazepines

The number of presentations to treatment in the UK in 2014 reporting a secondary benzodiazepine problem ($n = 6,033$) was over two and a half times greater than the number of presentations reporting a primary benzodiazepine problem ($n = 2,102$). A large percentage of primary benzodiazepine users also reported secondary problems with other drugs; cannabis being the most frequently reported secondary drug (22.0% of primary benzodiazepine users, $n = 444$). A large number of primary benzodiazepine users also cited problems with alcohol (11.2%; $n = 227$).

Age

The mean age of treatment presentations in 2014 was 31.9 years (± 10.7 years). However, those who had never previously received treatment tended to be younger (27.5 years ± 11.4 years). Of all clients accessing treatment, males tended to be older than females (32.2 years ± 10.7 years and 31.1 years ± 10.9 years respectively), but the ages across genders were more similar in new treatment entrants (27.5 years ± 11.1 years in males and 27.6 years ± 12.2 years in females).

Of all clients accessing treatment in 2014, those accessing treatment for heroin, crack cocaine and benzodiazepines tended to be older (36.1 years ± 8.3 years, 36.6 years ± 9.3 years and 36.3 years ± 13.2 years, respectively) than those accessing treatment for cannabis, MDMA and volatile substances (23.3 years ± 10.7 years, 22.2 years ± 7.7 years and 23.6 years ± 12.4 years, respectively). This pattern was seen irrespective of gender or treatment history.

Since 2003/04 the percentage of primary heroin users entering treatment who are over the age of 40 years has more than trebled, increasing from 10% to 32.5% in 2014; this is reflective of the static population of an ageing cohort.

Age of first use

Among all those entering treatment, the average age of first use of a drug was 20.2 years (+/- 7.9 years). This was similar for males (20.0 years +/- 7.7 years) and females (20.6 years +/- 8.4 years), and was also similar among those who were new to treatment as well as those who had previously received treatment. In general, the age of first use of cannabis and volatile substances was lower than for other drugs (14.6 years +/- 4.1 years and 16.1 years +/- 7.7 years for all those in treatment). This was similar regardless of gender and history of previous treatment.

The age of first use for barbiturates for all those entering treatment was 20.6 years (+/- 10.2 years). However, this varied from 14.0 years (+/- 1.4 years) for those new to treatment to 25.0 years (+/- 11.5 years) for those having previously received treatment. This was similar regardless of gender.

Injecting status

The majority (59.9%) of clients presenting to treatment reported that they had never injected drugs with 15.9% reporting current injecting.⁹⁴ Previously treated clients were three times more likely to report currently injecting than new treatment clients (see Table 5.2). Primary opioid users account for 92.1% of current injectors, with amphetamine users accounting for 2.5%. Heroin users were also most likely to inject, with nearly two-fifths (38.3%) of treatment entrants citing injecting as their primary route of administration. Although accounting for small numbers, a high proportion of methamphetamine users (46/157 [29.3%]) were recorded as injectors.

Table 5.2: Injecting status amongst all clients entering treatment in the United Kingdom, 2014

INJECTING STATUS	NEW TREATMENT CLIENTS		PREVIOUSLY TREATED CLIENTS		ALL CLIENTS	
	n	%	n	%	n	%
Ever injected, but not currently	2,380	8.2	19,133	31.7	21,891	24.2
Currently injecting (in last month)	1,928	6.7	12,368	20.5	14,381	15.9
Never injected	24,644	85.1	28,841	47.7	54,096	59.9
Sub Total	28,952	100	60,432	100	90,368	100
Not known/missing	6,055		3,187		10,088	
Total	35,007		63,529		100,456	

*Data on current injecting are not available for Wales as the item asks for ever injected (which has been mapped to ever but not currently) and never injected.

Source: ST34

5.4.4 Treatment Demand Indicator trends

All treatment entrants

Due to the introduction of a new methodology for calculating TDI, differences between 2013 data and previous years should be interpreted with caution. Both the increase in proportion of cannabis presentations and the decrease in opioid presentations from 2011/12 to 2013 will have been exaggerated by the introduction of the new TDI protocol and should not be treated as one time series.

⁹⁴ Data on current injecting are not available for Wales as the item asks for ever injected (which has been mapped to ever but not currently) and never injected

Since 2003/04, the percentage of primary cannabis presentations steadily increased from 10.7% of all presentations through to 22.4% in 2011/12 (the last year of the previous protocol). There has also been a decrease in the percentage of all clients accessing treatment for primary opioids from a peak of 71.4% in 2003/04 to 56.4% in 2011/12 (see Table 5.3).

Presentations for primary crack cocaine increased from 5.4% in 2003/4 to 6% in 2008/09. However, they have since declined and accounted for 3.2% of the treatment cohort in 2014.

Table 5.3: The percentage of all drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2014

DRUG		2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2013	2014
Amphetamines	%	3.7	3.6	3.5	3.8	3.5	3.2	3.2	3	2.8	2.6	2.8
Benzodiazepines	%	2.1	2.4	1.9	1.8	2	1.9	2	2.1	2.5	2.6	2.2
Cannabis	%	10.7	14.1	15.8	15.6	16.4	17.1	19.6	20.3	22.4	26.8	26.0
Cocaine*	%	4	4.9	5.8	6.9	8	8.5	7.6	7.4	8	9.4*	9.4*
Crack cocaine	%	5.4	5.6	5.8	5.8	5.9	6	4.5	4.8	4.6	3.5	3.2
Opioids	%	71.4	67	65.1	63.7	61.9	61.2	60.8	59.3	56.4	50.3	52.1
Other	%	2.7	2.5	2.1	2.4	2.4	2.1	2.6	3	3.4	4.8	4.3
Not known	%	7.2	11	7.3	4.7	3.5	3.9	3.7	4	3.8	2.6	3.5
Total	n	99,763	117,781	128,446	128,208	132,003	139,390	127,993	119,652	113,814	101,753[†]	100,456

*includes cocaine powder and cocaine unspecified

[†]figures are not directly comparable to previous years due to changes in TDI protocol

Source: ST34

New treatment entrants

Despite recent rises in the percentage of first ever treatment presentations for cannabis, between 2013 and 2014 the proportion fell from 48.6% to 46.6%. Conversely, whilst the overall percentage of primary opioid clients has been decreasing from a peak of 57.8% in 2003/04 to 33.4% in 2011/12, it showed a slight increase between the first two years of the new protocol from 19.7% in 2013 to 23.2% in 2014 (see Table 5.4).

By 2011/12 (under the old protocol), the proportion of new treatment entrants citing primary cannabis had overtaken that for primary opioids and this remained the same in 2013 and 2014 using the new protocol. The new protocol gives a better indication of treatment demand because it does not double count those transferred between agencies within a continuous treatment journey, which is disproportionately the case for opioid users.

Comparisons of clients accessing treatment across the UK

While England and Wales have seen decreases in the number of referrals to treatment since 2006/07, NI saw sharp increases between 2006/07 and 2011/12 followed by three years of decreases (Figure 5.1).⁹⁵ In 2013/14 the number of clients referred to treatment in NI had fallen to a level lower than that seen in 2010/2011. Conversely, Scotland saw decreases in the number of referrals to treatment between 2006/07 and 2011/12 followed by two years of increases in 2013 and 2014.

⁹⁵ Data indexed to 2006/07

Table 5.4: The percentage of first time drug treatment presentations by primary drug in the United Kingdom, 2003/04 to 2014

DRUG		2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2013	2014
Amphetamines	%	5.1	4.1	3.9	4.3	4.4	3.8	3.3	3.6	3.3	2.8	3.4
Benzodiazepines	%	2.3	3.1	2.5	1.9	2.9	2.5	3	3.1	3.9	3.8	2.9
Cannabis	%	18.6	22.1	24.8	24	27.2	28	32.5	32.4	37.1	48.6	46.6
Cocaine*	%	5.8	7.7	9.1	10.5	13.3	15.1	12.4	11.4	12.9	14.6*	14.7*
Crack cocaine	%	6	6.6	6.7	6.1	6.3	6.7	4.6	4.6	4	2.4	2.2
Opioids	%	57.8	52.3	50	45.7	42.5	41	40.4	40	33.4	19.7	23.2
Other	%	4.6	3.9	3.3	3.1	3.5	3.1	3.8	4.9	5.4	8.1	7.0
Not known	%	3.5	8.0	6.6	4.2	3.4	3.0	4.3	5.4	5.6	2	2.7
Total	n	29,865	42,497	49,625	47,165	46,601	45,048	44,924	47,566	43,110	35,229[†]	35,007

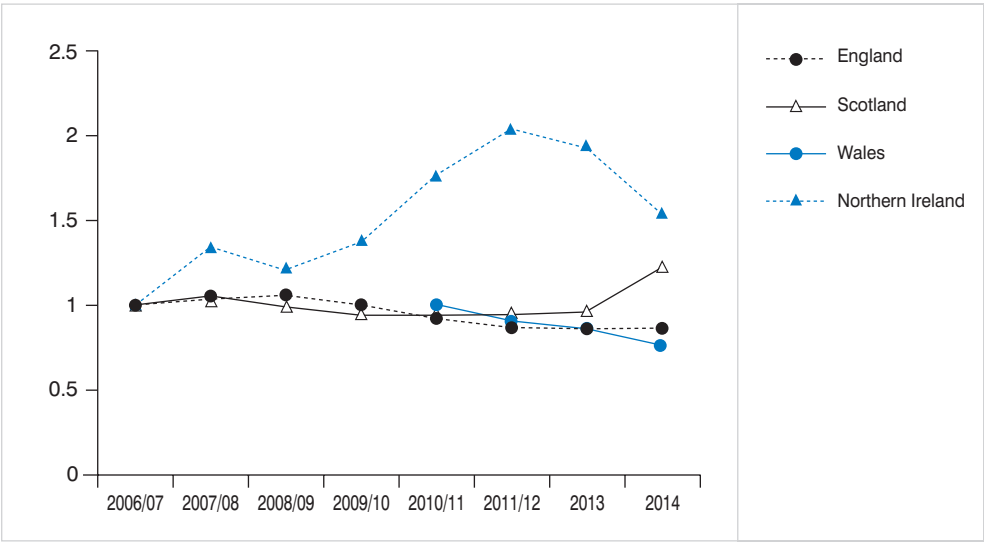
*includes cocaine powder and cocaine unspecified

[†]figures are not directly comparable to previous years due to changes in TDI protocol

Source: ST34

Opioids are the most commonly cited primary drug group for those entering treatment in England (52.1%), Scotland (56.9%) and Wales (57.6%); however, this group accounts for only 22.7% of those accessing treatment in NI.

Figure 5.1: The number of new presentations to treatment in England, Wales, Northern Ireland and Scotland, 2006/07 to 2014 (data indexed to 2006/07)



Source: ST34

5.5 Clients in treatment

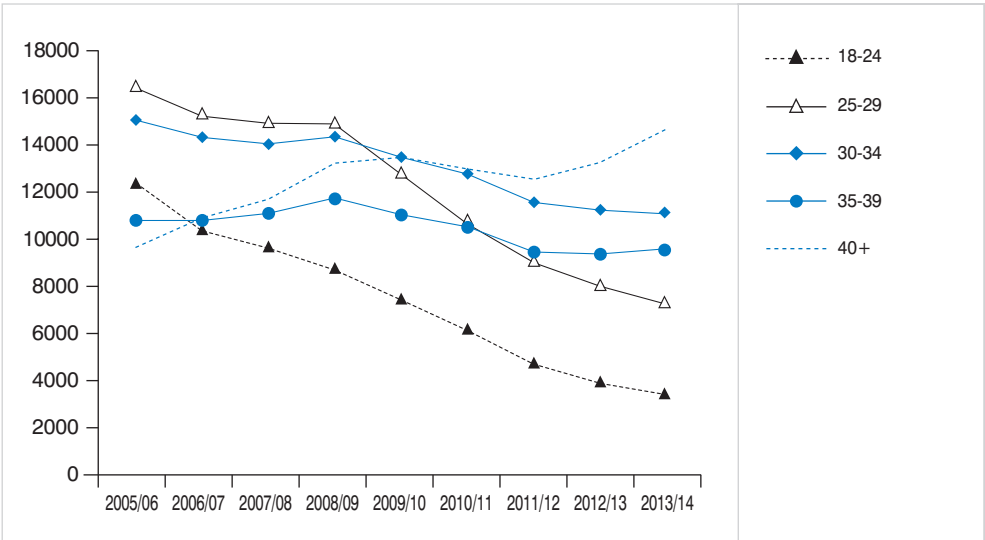
Data on clients in treatment for substance misuse are available from England, Wales and Scotland. In Northern Ireland, a census of those in treatment on a certain day is carried out every two years with the most recent carried out in 2014.

5.5.1 Data from the National Drug Treatment Monitoring System in England

In 2013/14 there were 193,198 individuals over the age of 18 in drug treatment in England; a slight decrease from the previous year ($n=193,575$) and a continuation of the decreasing trend in numbers in treatment that started in 2009/10 (Public Health England, 2014a). This reduction is principally driven by decreases in the number of new treatment journeys for opioids and/or crack cocaine. Between 2005/06 and 2013/14, decreases in treatment presentations for opioids and/or crack have occurred in all age groups except those over 40 (see Figure 5.2). These decreases mirror reductions in estimates of the prevalence of problem drug use (PDU) and suggest an ageing cohort of opioid and/or crack cocaine users. In contrast, the number of new journeys for cannabis, which has increased every year since 2005/06, continued rising from 11,280 in 2012/13 to 11,821 in 2013/14.

Most clients in contact with treatment were using opioids (79%). Cannabis was the primary drug for nine per cent of clients and powder cocaine for five per cent of clients (Public Health England, 2014a).

Figure 5.2: The number of new treatment presentations for opioids and/or crack cocaine by age group in England, 2005/06 to 2013/14



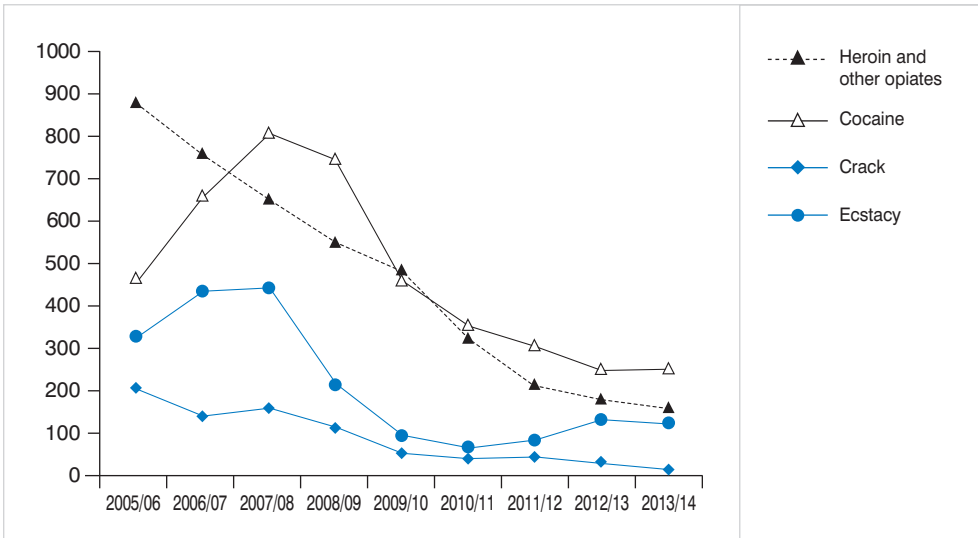
Source: (Public Health England, 2014a)

Young people in treatment in England

The number of young people (aged 17 years and under)⁹⁶ attending specialist substance misuse services for drugs or alcohol during 2013/14 was 19,126, down from 20,032 in 2012/13 (a 4.5% decrease) (Public Health England, 2014g). This decrease is in line with decreases in self-reported alcohol and drug use among young people (Fuller, 2015). Of the young people entering specialist services during the year, 99% waited less than three weeks from the point of referral to the first appointment, with the average wait of just under two days (Public Health England, 2014g).

Cannabis remains the most cited primary drug for which young people present to treatment in England. Despite a decline in self-reported cannabis use, the proportion of young people presenting to specialist services in 2013/14 for cannabis increased to 71% compared to 68% in 2012/13 (Public Health England, 2014g). In 2013/14, the number of young people citing heroin as their primary substance fell to a historic low of 160, continuing the decreasing trend since 2005/06 and mirroring the adult treatment data. Following five years of decreasing powder cocaine presentations (806 in 2007/08 to 245 in 2012/13), the figure remained stable in 2013/14 at 254 (see Figure 5.3). A decrease in the number of presentations for amphetamines was observed; 591 in 2013/14 from 755 in 2012/13. The number of presentations for solvents also continued to fall from 163 in 2013/14 to 134 in 2013/14.

Figure 5.3: The numbers of under-18s in treatment for the primary problematic use of individual class A drugs in England, 2005/06 to 2013/14



Source: (Public Health England, 2014g)

Club drug users in treatment in England

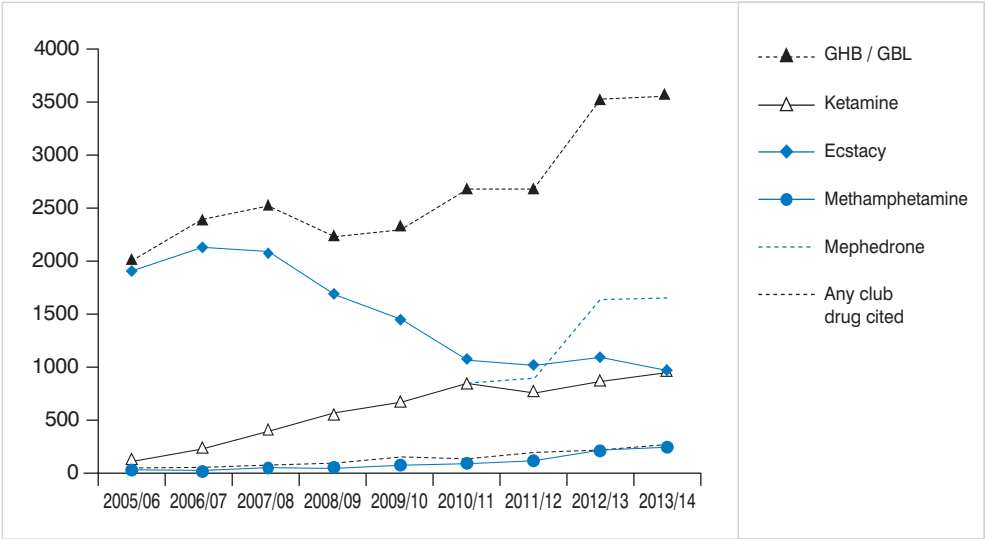
'Club drugs' is a collective term for a number of different substances, including GHB/GBL, ketamine, ecstasy, methamphetamine and mephedrone, typically used by young people in bars and nightclubs, at concerts and parties.

Between 2011/12 and 2012/13 there was a steep increase in the number of clients aged 18 or over presenting to treatment for any club drug, from 2,675 to 3,536 (Public Health England, 2013). This figure has remained stable in 2013/14 ($n = 3,543$) (Public Health England, 2014a) and represents five per cent of those presenting to treatment in 2013/14.

⁹⁶ NDTMS records clients aged nine upwards

Between 2012/13 and 2013/14 the numbers presenting to treatment for each of the five substances, with the exception of ecstasy, increased. Presentations for ecstasy have fallen to 964, nearly half the number presenting in 2005/06 ($n = 1,872$). Conversely, presentations for mephedrone have almost doubled since being added to the NDTMS in 2010/2011, rising from 839 to 1,641 in 2013/14. Ketamine presentations have risen by approximately 40% between 2010/2011 and 2013/14, from 675 to 944. Despite these rises in numbers entering treatment, self-reported use in the last 12 months among adults aged 16 to 59 for both mephedrone and ketamine was 0.5%, with the majority of users (71% and 70% respectively) reporting taking drugs just “once or twice a year” (Home Office, 2015f).

Figure 5.4: The number of new treatment presentations for club drugs in England, 2005/06 to 2013/14



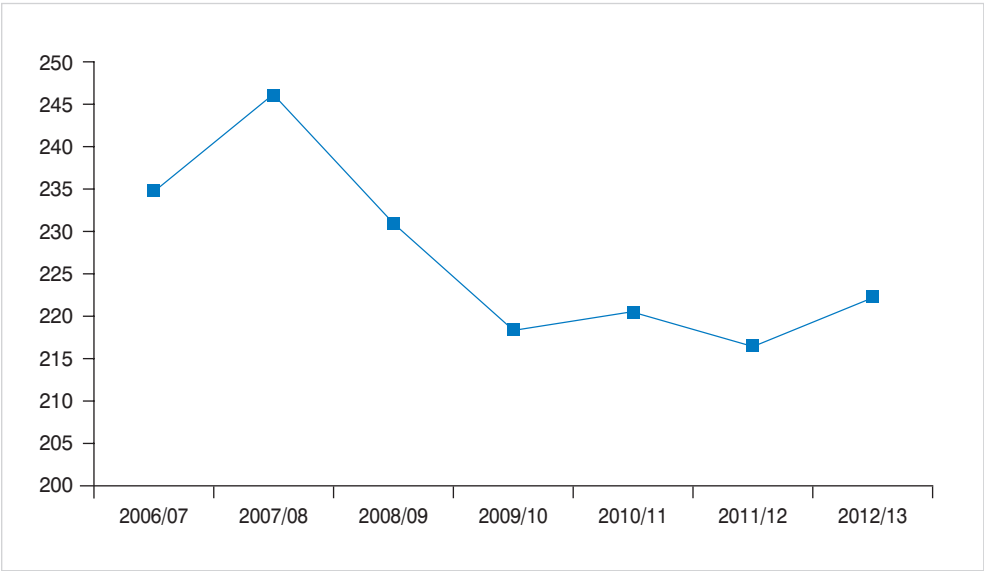
Source: (Public Health England, 2014a)

5.5.2 Data from the Scottish Drug Misuse Database

In 2012/13, 11,861 individuals had an initial assessment for specialist drug treatment, equivalent to a European Age-sex Standardised Rate (EASR) of 222 per 100,000 population (Information Services Division, 2014a). The overall EASR has fluctuated since 2006/07, reaching a maximum of 246 in 2007/08, but has been stable at approximately 220 per 100,000 of the population since 2009/10 (see Figure 5.5). Similar to the pattern observed in English data, since 2006/07, an increasing proportion of individuals from older age groups have been assessed for specialist drug treatment each year. In 2006/07, half (51%) of the individuals were aged 30 and over, compared with two-thirds (66%) in 2012/13.

In the majority of Scottish Health Boards, the proportion of individuals reporting heroin as their main illicit drug used in the past month decreased between 2011/12 and 2012/13. In almost all Health Boards, fewer younger people reported heroin use at their initial assessment. Again, this is in line with the trend reported over recent years (in 2006/7, 58% of those under the age of 25 reported using heroin, falling to 34% in 2011/12). There was no change in injecting behaviour in the majority of health boards between 2011/12 and 2012/13, but the percentage of people who reported injecting in the previous month fell notably across most Health Boards between 2006/7 and 2012/13.

Figure 5.5: Clients entering treatment in Scotland, 2006/07 to 2012/13, European Age-sex Standardised Rate per 100,000 of the population



Source: (Information Services Division, 2014a)

5.5.3 Data from the Welsh National Database for Substance Misuse

In 2013/14, the number of new referrals to treatment citing drugs⁹⁷ in Wales was 11,142, a decrease from 11,393 in 2012/13 (Welsh Government, 2014b).⁹⁸ The distribution of males/females has remained broadly consistent across the years; 72% of all clients referred were male and 28% female in 2013/14. The number of clients citing problematic use of opioids has slightly increased to 5,010 in 2013/14 from 4,931 in 2012/13, with heroin remaining the most cited drug at treatment referral, accounting for 39% of all referrals for which drugs were specified as the main problematic substance. Cannabis (24%) and cocaine (7%) were the next most common primary drugs cited at referral.

5.5.4 Data from the Northern Ireland Drug Misuse Database

In NI in 2013/14, a total of 2,574 clients presented to services for problem drug misuse; nine per cent lower than in 2012/13 (2,824 clients) (Department of Health Social Services and Public Safety Northern Ireland, 2013). The number of clients presenting to treatment has increased from 1,409 in 2003/04.

5.5.5 Data from Northern Ireland treatment census

On 1 September 2014 a census was done of those receiving treatment for alcohol or substance misuse in Northern Ireland. Findings show that there were 4,662 people in treatment in NI for either drugs only or a combination of drug and alcohol (Department of Health Social Services and Public Safety Northern Ireland, 2015a). Sixty-six per cent of clients in treatment for drugs only were male and 13% were under 18. Between 2007 and 2014 the proportion of clients in treatment for both drugs only and for drugs and alcohol has risen from 20% to 31% and from 18% to 24% respectively. However, this figure rose when age and gender were accounted for, with 42% of males and 36% of females under 18 years old in treatment for drugs only.

⁹⁷ Where there is a known substance type

⁹⁸ Figures will not match referenced figures as they exclude alcohol as a primary drug type

5.5.6 Opioid Substitution Treatment

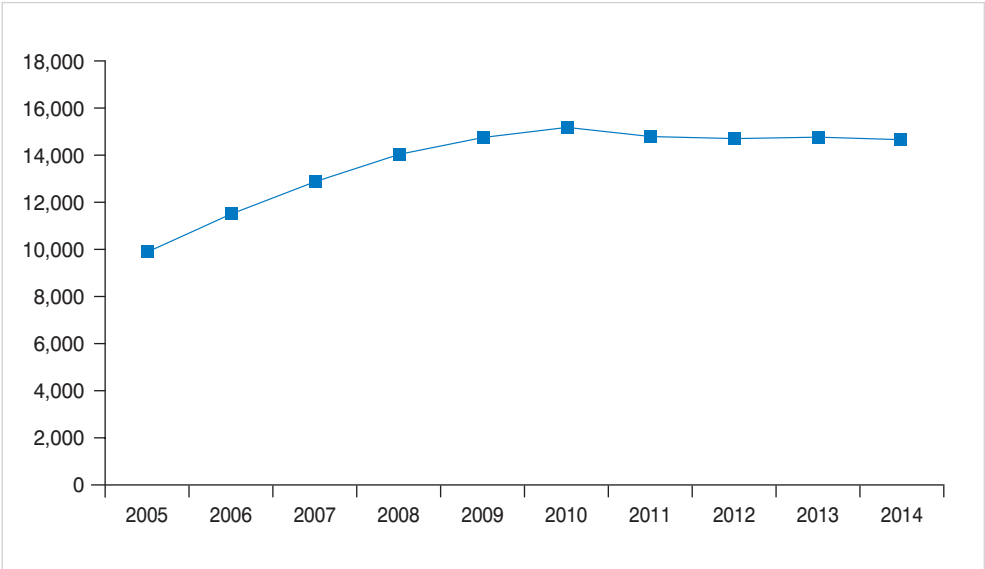
In the UK OST can be prescribed and managed by any GP, although the vast majority is received through structured treatment services where clients are encouraged to also engage in other forms of treatment such as psychosocial intervention, counselling and/or groups. Both methadone and buprenorphine are recommended in NICE guideline TA114⁹⁹ as treatment options for people who are opioid dependent. Methadone currently remains the most commonly prescribed drug for OST.

England

Data show that the number of opioid users in prescribing treatment increased from 98,991 in 2005 to 152,828 in 2010. It has since stabilised and in 2014 OST was prescribed to 146,875 clients in England, a slight decrease from the 147,640 recorded in 2013 (see Figure 5.6).

In 2014 two-thirds (66%) of those entering treatment in the UK with a primary drug of opioids, who had previously been treated, had received OST in the past.

Figure 5.6: Trends in numbers of clients in England receiving opioid substitution treatment, 2005-2014



Source: ST24

Wales

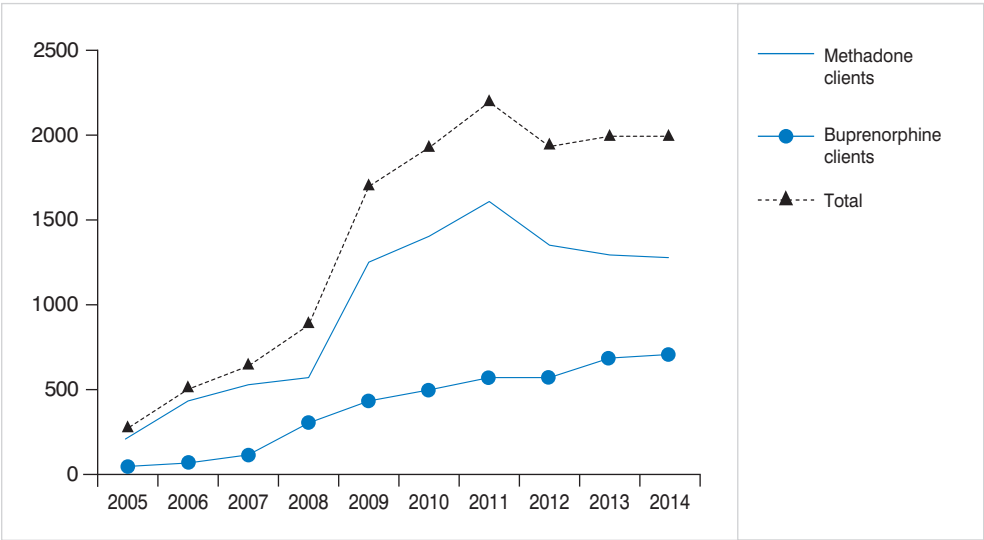
In Wales there was a steep increase in the total number of OST clients between 2005 and 2011, from 275 to 2,208.¹⁰⁰ This was followed by a fall in 2012 to 1,925 and a slight rebound in 2013 to 1,995 clients where it remained stable to 2014 ($n = 1,993$) (see Figure 5.7).

During 2014 two-thirds of clients in OST ($n = 1,278$) were prescribed methadone, whilst the remaining third ($n = 715$) received buprenorphine. However, the number of clients receiving buprenorphine has been steadily increasing over the last decade from 46 in 2004 (ST24).

⁹⁹ See: <https://www.nice.org.uk/guidance/ta114>

¹⁰⁰ Due to a change in the Welsh dataset and a number of duplicate records being deleted from the database these figures will not match those reported in previous years

Figure 5.7: Trends in numbers of clients in Wales receiving opioid substitution treatment, 2005-2014



Source: ST24

Scotland

In almost all NHS Health Boards, methadone was currently prescribed in over half of assessments where a prescription drug was reported. Diazepam was the second most commonly prescribed drug reported at assessments for drug treatment in 2012/13.

In 2014/15, there were over 531,100 OST items dispensed in the community; some 439,800 of these were for methadone treatments. Overall the number of OST items dispensed decreased by 3.2% compared to 2013/14. Methadone dispensing decreased by 5.4% and has been decreasing year-on-year since 2010/11.

Prescription cost analysis shows that the prescribing of drugs other than methadone for the treatment of opioid dependency has been steadily increasing. For example, the number of items dispensed for the combined drug buprenorphine and naloxone (Suboxone®) increased by over 28% between 2012/13 and 2013/14.

5.5.7 Treatment outcomes

The Treatment Outcomes Profile (TOP) is a clinical tool that enables clinicians and drug workers to keep track of the progress individuals make through their treatment journey.¹⁰¹ It measures drug use and gives an early indication about clients' progress in overcoming problems with work, education or housing through a set of 20 questions.¹⁰² TOP was introduced in England in 2007 and has also been used in Wales since 2009. In Scotland, from 2008 an enhanced, web-based SDMD follow-up reporting system was introduced to collect information on individuals throughout their treatment, not just at initial assessment. TOP data from England and Wales is not comparable due to differences in reporting methodology.

¹⁰¹ A TOP assessment is completed at treatment entry and then should be completed every three months and on treatment exit.
¹⁰² See: <http://webarchive.nationalarchives.gov.uk/20150408180724/http://www.dtmu.org.uk/sph-files/top/TOP-form-v1.1-Aug%202008.pdf>

Treatment Outcomes Profile data in England

Table 5.5 shows the mean number of days use of a drug reported at treatment start and review and the percentage of clients reporting abstinence of that drug at treatment review in England (Public Health England, 2014a). The mean days use¹⁰³ of a drug at treatment start was highest for cannabis (22 days), followed by opioids (21 days), amphetamines (16 days), crack cocaine (11 days) and cocaine powder (10 days).

Table 5.5: Self-reported drug use by Treatment Outcome Profiles and the percentage of abstinent clients at treatment start and review in England

DRUG	MEAN DAYS USE OF DRUG AT TREATMENT START	MEAN DAYS USE OF DRUG AT TREATMENT REVIEW	PERCENTAGE OF CLIENT ABSTINENT AT TREATMENT REVIEW
Opioids	21.4	6.3	48%
Crack	11.1	3.8	60%
Powder cocaine	9.7	2.2	65%
Amphetamines	15.7	6.2	51%
Cannabis	22.1	11.3	36%

Source: (Public Health England, 2014a)

English data revealed that users of both opioids and crack cocaine reduced their days of illicit opioid use by less than opioid only users (mean days use of drug at treatment review was eight days compared to six days out of the last 28 days) (Public Health England, 2014a). Users of cocaine powder and users of crack cocaine only were most likely to be abstinent at review (65% and 60% respectively) with cannabis users least likely to be so (36%).

Treatment Outcomes Profile data in Wales

Based on TOP data in Wales, for those with a main problematic substance of heroin, the average number of days of heroin use fell from 24.5 to 9.3 (-61.8%), with 59.1% having not used heroin at all in the 28 days prior to the exit TOP (Welsh Government, 2014b). Reductions were greater in clients citing use of powder cocaine, where the average number of days of powder cocaine use fell from 10.3 to 2.9 (a 72% reduction). Reductions were also seen in clients who used cannabis from 24.9 days to 15.2 (a 39.0% reduction), with 32.5% not having used cannabis at all in the 28 days prior to the exit TOP. Finally, the change in frequency in the use of amphetamines between start and exit TOPs fell from 21.8 to 11.3 days (a 48.3% reduction), with 67.9% having not used amphetamines at all in the 28 days prior to the exit TOP.

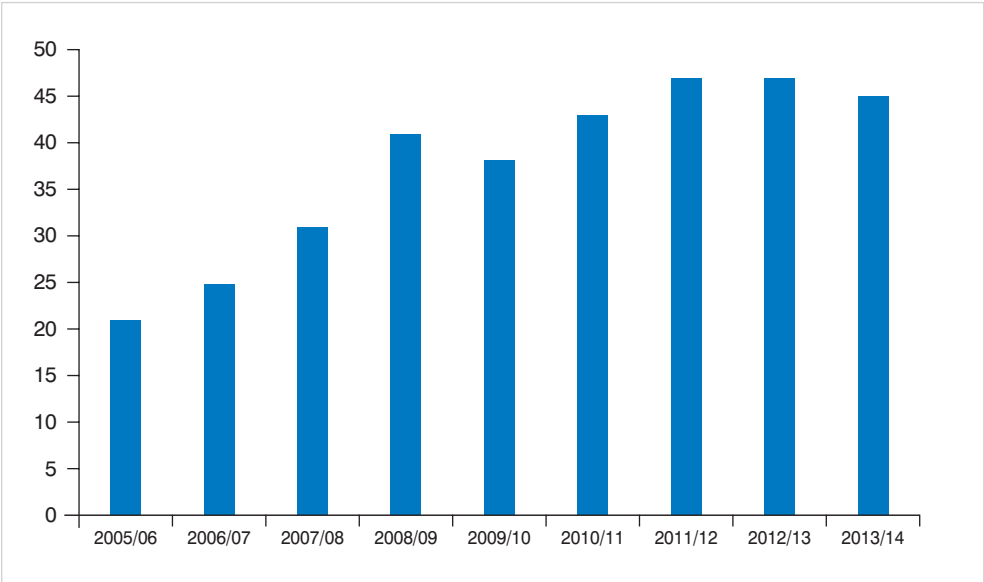
Clients leaving treatment successfully in England in 2013/14

The number of clients leaving treatment successfully in England has levelled off following an increasing trend since 2005/06 (Public Health England, 2014a). The number of clients discharged as 'treatment completed'¹⁰⁴ remained stable between 2012/13 and 2013/14 at 29,025 and 29,150 respectively (45% of clients exiting treatment) (see Figure 5.8). Successful completions as a percentage of the total number of people in treatment remained at around 15% in 2013/14 and 2012/13. Since 2005, approximately one-third (33%) of people who have come into treatment have been successfully completed and have not since returned.

¹⁰³ Self-reported use in the 28 days prior to starting treatment.

¹⁰⁴ This is determined by clinical judgement that the client no longer has a need for structured treatment, having achieved all the care plan goals and having overcome dependent use of the drugs that brought them into treatment.

Figure 5.8: The proportion of clients leaving treatment free from dependency in England, 2005/06 to 2012/13



Source: (Public Health England, 2014a)

Young People

In 2013/14 12,510 individuals under the age of 18 exited treatment, 79% of whom did so in a planned way and no longer required specialist treatment (Public Health England, 2014g).

6. Drug-related infectious diseases and other drug-related harms

6.1 Introduction

People who use drugs are at risk of both fatal (Hickman et al., 2003) and non-fatal overdose (Gossop, Griffiths, Powis, Williamson, & Strang, 1996); experiencing periods of elevated overdose risk in the immediate period after leaving inpatient treatment and prison (Cornish, Macleod, Strang, Vickerman, & Hickman, 2010; Farrell & Marsden, 2008); and experiencing greater risk of contracting blood-borne viruses (BBVs) through injecting drug use (Judd et al., 2004).

The United Kingdom (UK) Government and devolved administrations have a number of policy and guidance documents outlining best practice for responses to the health correlates and consequences of drug use (often referred to as harm reduction). Generally, harm reduction is the combination of work aimed at reducing the number of drug-related deaths and BBVs and other infections, with the wider goals of preventing or reducing drug misuse and encouraging stabilisation in treatment and support for recovery. Principles of harm reduction aim to reduce the risky behaviour of those active drug users, who are either unwilling or unable to abstain. Each of the UK and devolved administration drug strategies include harm reduction objectives such as reducing drug-related harm and the prevention and control of drug-related infectious diseases.

In Wales, the 10-year substance misuse strategy, *Working Together to Reduce Harm. The Substance misuse strategy for Wales 2008-2018* (Welsh Assembly Government, 2008a) was published in 2008, setting out a national agenda for tackling and reducing the harms associated with substance misuse. In 2014, Public Health Wales (PHW) issued guidance on *Diagnostic Testing for Hepatitis C, Hepatitis B and HIV* (Public Health Wales, 2014) aimed at those who work in substance misuse services. Additionally, the *Blood Borne Viral Hepatitis Action Plan for Wales 2010-2015* (Welsh Assembly Government, 2010) was published in 2010 with the key aims of reducing the transmission of hepatitis infections in Wales; increasing the diagnosis of current infections; and improving the provision of treatment and support to infected individuals. The Action Plan was followed by the new *Together for Health – Liver Disease Plan* published by the Welsh Government in May 2015 (Welsh Government, 2015a) which sets out priorities to improve treatment services and prevent liver diseases relating to alcohol, obesity and viral hepatitis.

The Scottish Government launched the *HIV Action Plan in Scotland, December 2009 to March 2014* (Scottish Government, 2009b) in November 2009. The plan aimed to reduce the number of transmissions occurring in Scotland through increased prevention, increased early diagnosis and the improvement of the treatment and care of those living with the virus. The five year framework, the *Sexual Health and Blood Borne Virus Framework 2011-2015* (Scottish Government, 2011), integrated the aforementioned program with sexual health and hepatitis and set out the Scottish Government's agenda in relation to sexual health, HIV, hepatitis C and hepatitis B until 2015. The framework adopts an outcomes-based approach anchored by effective shared ownership and joint working with a strong focus on challenging inequalities. Quality standards applicable to all HIV services (Health Improvement Scotland, 2011) and quality indicators applicable to all hepatitis C services (Health Improvement Scotland, 2012) were also published in Scotland.

In England, the *Drug Strategy 2010, Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life* (Her Majesty's Government, 2010) includes a key best practice delivery outcome that all drug services are commissioned to prevent drug-related deaths and prevent the spread of BBVs. Public Health England (PHE) routinely publishes guidance on best practice and reports annual surveillance on a range of key indicators associated with BBVs in the UK. In April 2014, PHE launched its 'Big Ambitions', which include tuberculosis (TB).¹⁰⁵

¹⁰⁵ See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319696/Business_plan_11_June_pdf.pdf

In Northern Ireland, responses to health correlates and consequences of drug misuse are broadly covered by the overarching strategy for alcohol and drugs misuse, the *New Strategic Direction for Alcohol and Drugs Phase 2, 2011-2016* (Department of Health Social Services and Public Safety Northern Ireland, 2011b). One of the overall aims of the new strategic direction is to reduce drug-related harm and ensure continued support to further develop appropriate harm reduction approaches and strategies.

6.2 Main drug-related infectious diseases

6.2.1 HIV and viral hepatitis

HIV

The overall prevalence of HIV seen amongst people who inject drugs (PWID) in 2014 was similar to that seen in recent years. The prevalence of HIV amongst the current and former PWID taking part in the Unlinked Anonymous Monitoring (UAM) Survey across England, Wales and Northern Ireland in 2014 was one per cent (95% CI, 0.07%-1.4%) (Public Health England, 2015). Between 2004 and 2013, prevalence varied between 1.1% and 1.6% (Public Health England, 2015) (see Figure 6.1). In 2014 the HIV prevalence was 1.1% (95% CI, 0.22%-3.4%) in Wales and 0.65% (95% CI, 0.01%-3.9%) in Northern Ireland (Public Health England, 2015). In England, the HIV prevalence was one per cent (95% CI, 0.69%-1.5%) in 2014, not significantly different from 2004 when the prevalence was 1.4% (95% CI, 1.0%-2.0%) (Public Health England, 2015).

HIV prevalence amongst “recent initiates” to injecting drug use (those who first injected during the preceding three years) is an indicator of recent HIV transmission. The prevalence amongst the recent initiates participating in the UAM Survey across England, Wales and Northern Ireland was 0.41% (95% CI, 0.01%-2.5%) in 2014 (Public Health England, 2015). This is similar to that found in recent years, indicating that HIV transmission amongst PWID is ongoing within the UK albeit at a low level (see Figure 6.1).

There were 131 new HIV diagnoses associated with injecting drug use reported in the UK during 2014; 17 of these diagnoses were reported from Scotland (Public Health England et al., 2015). There were also 33 reported HIV diagnoses that were associated with sex between men, for which injecting drug use was also reported as a risk (Public Health England et al., 2015).

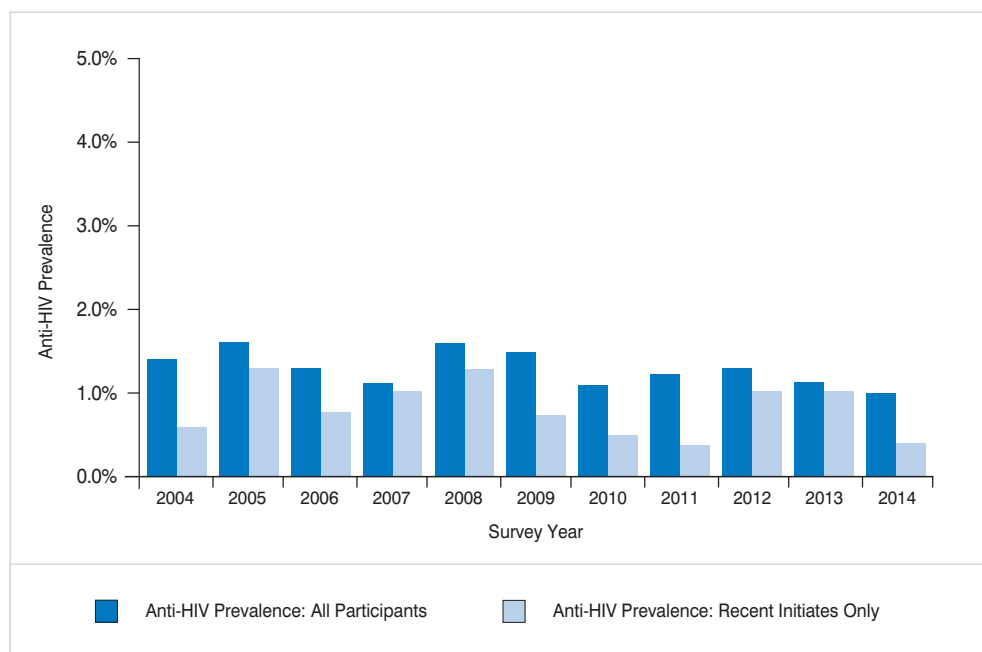
In the Greater Glasgow and Clyde area of Scotland, there has been a recent increase in the number of HIV infection diagnoses where the risk factor is injecting drug use. On average, 115 new diagnoses of HIV infection are made annually in the Greater Glasgow and Clyde area, with the majority of these being acquired through sexual transmission. The number of new diagnoses thought to be transmitted through injecting drug use is on average about ten per annum. By the end of August, there had been 36 new diagnoses with this risk so far in 2015. The cause of this increase is currently under investigation, but the increase is thought to be due to an outbreak. Three key messages have been issued as part of the local response: if injecting, use clean, fresh equipment and never share; use a condom for sex; and take an HIV test.¹⁰⁶

Hepatitis C

PWID are the group with the highest prevalence of hepatitis C in the UK. Around 90% of the hepatitis C infections diagnosed in the UK will have been acquired through injecting drug use. During 2014, 14,149 hepatitis C infections were diagnosed across the UK (Public Health England et al., 2015). There has been a marked increase in the annual number of new diagnoses throughout the UK over the last decade, reflecting the increased availability and easier access to voluntary confidential testing (VCT).

¹⁰⁶ See: <http://www.nhsggc.org.uk/about-us/media-centre/news/2015/06/hiv-infections-increase/>

Figure 6.1: The prevalence of antibodies to HIV amongst all participants and recent initiates* in the Unlinked Anonymous Monitoring Survey of people who inject drugs: England, Wales and Northern Ireland, 2004 to 2014



*A recent initiate is someone who first injected during the preceding three years

Source: (Public Health England, 2015)

The prevalence of hepatitis C infection amongst PWID remains relatively high. The overall prevalence of antibodies to hepatitis C (anti-HCV)¹⁰⁷ amongst the current and former PWID participating in the UAM Survey across England, Wales and Northern Ireland was 49% (95% CI, 47%-51%) in 2014 (Public Health England, 2015). This proportion has remained relatively stable over the last decade (see Figure 6.2). In 2014, in Northern Ireland anti-HCV prevalence was 32% (95% CI, 25%-39), which is lower than in England (50%, 95% CI, 49%-52%) and Wales (50%, 95% CI, 44%-56%) (Public Health England, 2015). While in England and Northern Ireland the hepatitis C prevalence amongst the participants in the UAM Survey has remained relatively stable over time, in Wales there has been an increase from 19% recorded in the period 2003–05 (Public Health England, 2015b). In England there were very marked regional variations from 29% in the north east region to 66% in the north west region (Public Health England, 2015b).

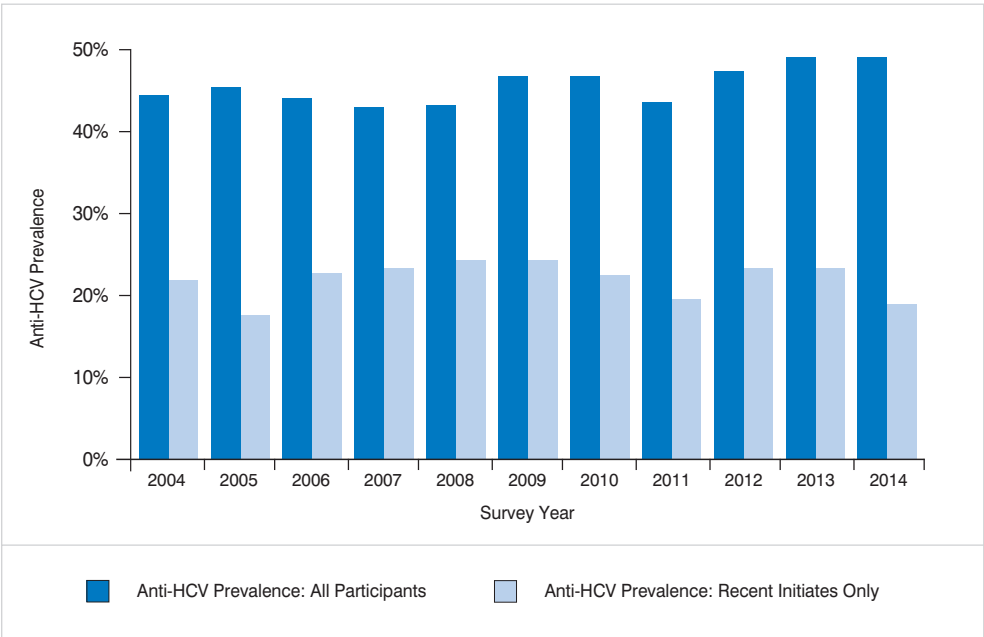
In Scotland, the estimated prevalence of antibodies to hepatitis C was 57% among current and former PWID surveyed at services providing injection equipment across mainland Scotland in 2013/14. This compares to 52%, 55% and 53% who tested positive in 2008/09, 2010 and 2011/12, respectively (Public Health England et al., 2015).

The level of hepatitis C transmission among PWID in the UK appears to have changed little in recent years. The prevalence of antibodies to hepatitis C amongst recent initiates has also been fairly stable. Amongst those in this group participating in the UAM survey from across England, Wales and Northern Ireland, prevalence was 19% (95% CI, 15%-25%) in 2014 (Public Health England, 2015). Over the last decade the prevalence in this group has ranged between 18% and 24% (Public Health England, 2015b). Incidence of hepatitis C infection among PWID in England, Wales and Northern Ireland is currently estimated to be between five to 16 infections per 100 person years of exposure (Public Health England,

¹⁰⁷ Anti-HCV is a marker of previous or current hepatitis C infection

2015f). In Scotland, the incidence of hepatitis C infections among PWID was estimated to be 10 infections per 100 person years of exposure during 2013/14; this compares with an incidence of 13 infections per 100 person years found during 2008/09 (Public Health England, 2015f).

Figure 6.2: The prevalence of anti-HCV amongst all participants and recent initiates* in the Unlinked Anonymous Monitoring Survey of people who inject drugs: England, Wales and Northern Ireland, 2004 to 2014



*A recent initiate is someone who first injected during the preceding three years

Source: (Public Health England, 2015b)

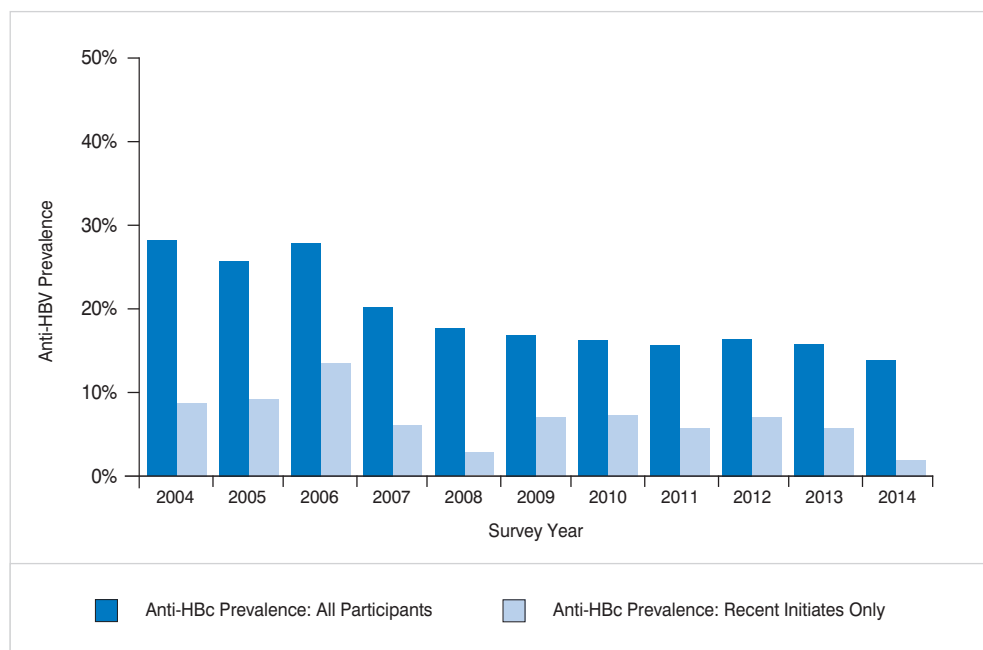
Hepatitis B

In 2014, 14% (95% CI, 13%-16%) of the current and former PWID who took part in the UAM Survey in England, Wales and Northern Ireland had antibodies to hepatitis B core antigen (anti-HBc, a marker of previous or current hepatitis B infection) (Public Health England, 2015l). This prevalence has remained relatively stable in recent years, but it is lower than the level seen ten years ago when prevalence was 28% (see Figure 6.3) (Public Health England, 2015l). The prevalence of anti-HBc varied by country: Northern Ireland, 7.1% (95% CI, 3.9%-12%; prevalence was 13% in 2004); Wales, 11% (95% CI, 7.9%-15%; prevalence was nine per cent in 2003-05); and England, 15% (95% CI, 14%-17%; down from 29% in 2004) (Public Health England, 2015b, 2015l).

The samples collected by the UAM Survey of PWID during 2014 that had anti-HBc detected were also tested for hepatitis B surface antigen (HBsAg), a marker of current infection. In 2014, of the samples from the UAM Survey of PWID with anti-HBc, four per cent (95% CI, 2.5%-6.3%) had HBsAg detected indicating current infection; this represents 0.58% (95% CI, 0.36%-0.93%) of all the PWID surveyed in England, Wales and Northern Ireland that year (Public Health England, 2015l).

The available data on reports of acute hepatitis B infections indicate that currently few of these are among PWID, with most UK acquired cases associated with sexual activity. These findings indicate that current hepatitis B infection is now rare among PWID, probably reflecting the impact of the marked increase in the uptake of the hepatitis B vaccine among PWID (Public Health England et al., 2015).

Figure 6.3: The prevalence of anti-HBc amongst all participants and recent initiates* in the Unlinked Anonymous Monitoring Survey of people who inject drugs: England, Wales and Northern Ireland, 2004 to 2014



*A recent initiate is someone who first injected during the preceding three years

Source: (Public Health England, 2015)

6.2.2 Blood borne viral infections amongst people who inject image and performance enhancing drugs

Following a pilot UAM Survey of people who inject image and performance enhancing drugs (IPEDs) that was undertaken during 2010/11 (Hope et al., 2013), the first biennial monitoring survey was performed in 2012/13 (Public Health England, 2014b). The participants were principally recruited through needle and syringe programmes (NSP) across England and Wales over an 18 month recruitment period.¹⁰⁸ The participants provided a dried blood spot (DBS) specimen that was tested anonymously for HIV, hepatitis C and hepatitis B (the main tests used were for antibodies to HIV, hepatitis C and the hepatitis B core antigen). Behavioural and demographic information was collected using a short subject completed questionnaire.

During the 2012/13 sampling period 249 individuals took part in the IPED survey from across England and Wales. Of these, two per cent (95% CI, 0.74%-4.9%) had HIV (compared with 1.1% in PWID using psychoactive drugs), 2.8% (95% CI, 1.2%-5.9%) anti-HBc (compared with 16% in those PWID using psychoactive drugs), and 3.6% (95% CI, 1.8%-7.9%) had anti-HCV (compared with 49% in those PWID using psychoactive drugs) (Public Health England, 2014f). Though the prevalence of antibodies to both hepatitis B and C were lower than the prevalence found in people who inject psychoactive drugs, the prevalence of HIV was similar in both groups.

The prevalence of BBV infections amongst IPED injectors in Scotland and Northern Ireland is currently not known. A pilot survey of IPED injectors is currently under way in Northern Ireland. In Scotland, among those who had injected image and performance drugs only during the last six months, 5.1% had antibodies to hepatitis C in 2013/14.

¹⁰⁸ An 18 month recruitment period was used, instead of 12 months in the main UAM Survey of people who inject psychoactive drugs, due to the cyclic nature of some of the forms of drug use among this target population

6.3 Other drug-related infectious diseases

6.3.1 Tuberculosis

In total there were 6,520 cases of TB reported in England in 2014 (Public Health England, 2015k). Amongst the cases with known information on the four 'social risk factors' monitored among TB cases in England: 3.3% (201/6,031) had either a history of, or currently had, a problem with drug use; 3.3% (198/5,988) of alcohol misuse; 3.4% (206/6,062) of homelessness; and 3.3% (192/5,903) of imprisonment. A total of 9.4% of cases (538/5,708) had at least one of these social risk factors. A higher proportion of the UK born TB cases had at least one social risk factor when compared to non UK-born cases (15.0% versus 7.2%).

6.3.2 Infections due to spore-forming bacteria

Illnesses caused by the toxins produced by a number of spore-forming bacteria, such as botulism, tetanus or anthrax, continue to cause problems among people who inject drugs. The spores produced by these bacteria are found in the environment, and may end up in drugs, such as heroin, through contamination. There were three cases of botulism among people who inject drugs during 2014, and the last two were the first cases of the largest cluster of botulism cases among this group seen so far in Europe. Between 2000 and 2013, there had been a total 167 cases of botulism amongst people who inject drugs in the UK (Public Health England et al., 2015).

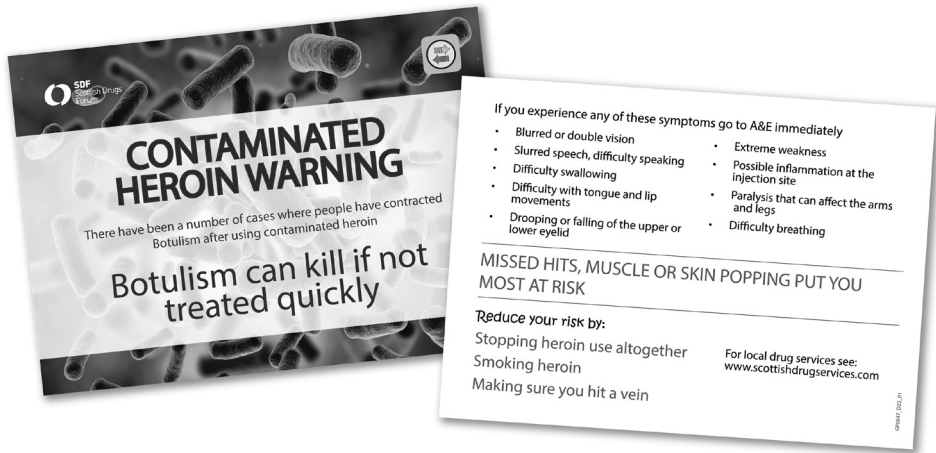
The recent cluster involved a total of 40 cases over a six month period between December 2014 and May 2015. Seventeen (42%) cases were confirmed by detection of the toxin in blood or detection of *Clostridium botulinum* type B in wound material. Molecular typing of the organism from 14 of the cases indicated a common source, and all cases had injected heroin sourced from the same Scottish city. Awareness-raising materials, highlighting the symptoms of botulism, were distributed widely among people who use drugs, healthcare professionals, and frontline workers in addictions and injecting equipment provision services (Figure 6.4). A pragmatic risk reduction approach was taken, advising users to make sure they injected their drugs into a vein, smoked drugs as an alternative to injecting, or if possible stopped use altogether (Public Health England et al., 2015).

There were no cases of tetanus or anthrax reported among people who inject drugs in the UK during 2014 (Public Health England et al., 2015).

6.3.3 Other injection-related bacterial infections

Severe illnesses among people who inject drugs due to hygiene-related bacterial infections, including those caused by *Staphylococcus aureus* and Group A streptococci, continue to occur. Data from the mandatory enhanced surveillance of methicillin-sensitive *S. aureus* (MSSA) and methicillin-resistant *S. aureus* (MRSA) bacteraemias indicate that in 2013, of those with risk factor information, 80% of the MSSA bacteraemias were associated with injecting drug use, as were 4.8% of the MRSA bacteraemias. Severe Group A streptococci infections have also been reported among people who inject drugs. There has recently been a large outbreak of soft tissue infections among people who inject drugs in Edinburgh (Public Health England et al., 2015). Though a number of different organisms were detected, Group A streptococci infections, and in particular one less commonly seen type of *S. pyogenes*, was often detected in the cases. Those involved had injected a range of drugs including a new psychoactive substance. Many cases required prolonged hospital admission and extensive surgical intervention (Health Protection Scotland, 2015).

Figure 6.4: Botulism health warning 'postcard' distributed to people who use drugs



Source: Scottish Drugs Forum www.sdf.org.uk / NHS Greater Glasgow and Clyde

In 2014, over one-quarter, 31% (95% CI, 29%-33%) of PWID participating in the UAM Survey in England, Wales and Northern Ireland reported that they had experienced an abscess, sore or open wound, all indicating symptoms of injecting-site infection, during the preceding year (Public Health England, 2015). This was similar to the level seen in recent years. The proportion of people reporting symptoms increased with age, from 24% amongst those aged under 25 years to 33% amongst those aged 35 years and over, with more women (37%) reporting symptoms than men (29%) (Public Health England, 2015b). Among those attending needle and syringe programmes in Scotland during 2013/14, 28% reported that they had experienced an abscess, sore or open wound during the last year (Public Health England et al., 2015).

Among the participants in the 2012/13 UAM sub-survey of people who inject IPEDs, 16% reported that they had ever experienced symptoms of injecting-site infection, with the proportion highest among the 25 to 34 age group (22%) (Public Health England, 2014b).

6.4 Behavioural data: infection risks

The extent and patterns of infections over time reflect changing patterns of risk. Risk will be impacted by the extent of service provision, particularly the provision and uptake of harm reduction and health protection interventions such as NSP, opioid substitution treatment (OST), vaccination, and diagnostic testing services. The provision of these services is widespread in the UK and provision and uptake have both improved across the UK over the last decade (see section 6.6).

6.4.1 Sharing of injecting equipment: people who inject psychoactive drugs

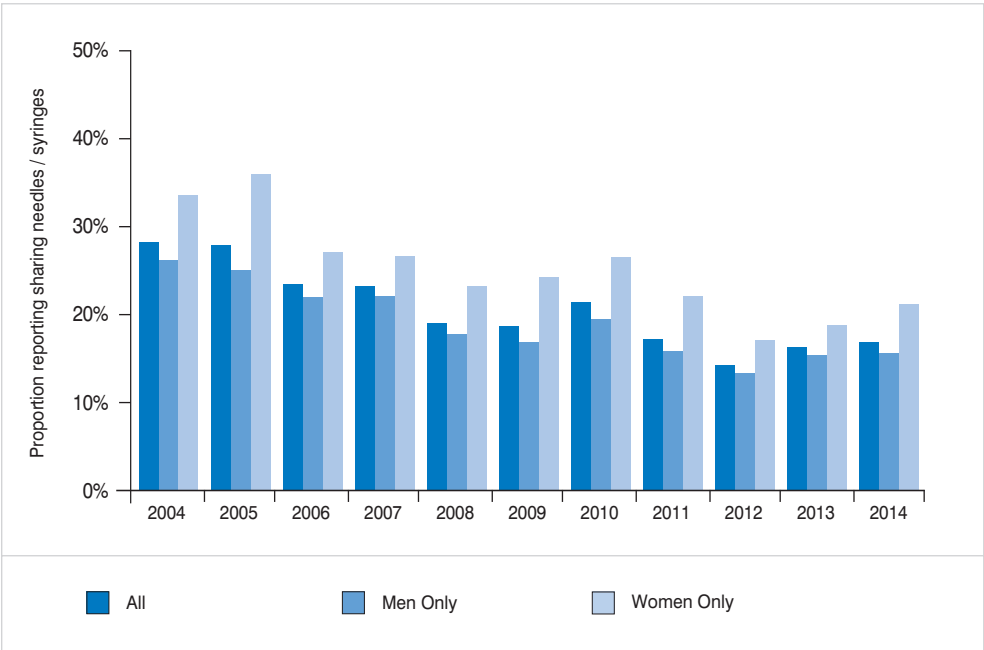
The level of needle and syringe (direct) sharing reported by participants in the UAM Survey in England, Wales and Northern Ireland has declined from 28% (95% CI, 26%-30%) in 2004 to 17% (95% CI, 15%-19%) in 2014 (Public Health England, 2015) (Figure 6.5). Throughout the 2004 to 2014 period, direct sharing levels were higher among women than men; in 2014, 21% (95% CI, 17%-26%) of women reported direct sharing compared with 15% (95% CI, 14%-18%) of men (Public Health England, 2015). Direct sharing was found to vary across England (16%), Wales (22%) and Northern Ireland (17%) (Public Health England, 2015b). In England regional variations were reported, ranging from 12% (95% CI, 5.5%-22%) in the east of England in 2014 to 23% (95% CI, 17%-30%) in the south-west of England (Public Health England, 2015).

Sharing of any of the injecting equipment asked about in the UAM Survey (i.e. needles, syringes, mixing containers, or filters; direct and indirect sharing) was reported by 38% of those participating in the survey in 2014; this was not significantly different from the previous year (Public Health England, 2015b). Sharing of any of this equipment was reported by 38% of the participants in England (regional range: 31% to 55%), by 41% in Wales, and by 30% in Northern Ireland in 2012 (Public Health England, 2015b).

In Scotland, data from the Scottish Drug Misuse Database (SDMD) indicates sharing of needles/syringes among those injecting drugs in the past month was generally low (less than 10%), ranging from two per cent to nine per cent between NHS Health Boards and remaining constant with the values reported in 2011/12 (Information Services Division, 2014a). However, the percentage of injectors reporting having shared needles/syringes in the past, but not in the previous month was higher (ranging from 18% to 44% between NHS Health Boards), remaining broadly similar to the previous year.

Among the injectors reporting sharing of injecting paraphernalia in the past month the percentages were low, with similar variation between NHS Health Boards (ranging from four per cent to 12%). Similar low values of injectors reporting recent sharing of paraphernalia since 2010/11 and decreasing from a higher percentage in 2006/07 (44%) were reported in all NHS Health Boards.

Figure 6.5: The percentage of current injectors* in the Unlinked Anonymous Monitoring Survey of people who inject drugs reporting needle and syringe sharing: England, Wales and Northern Ireland, 2004 to 2014



*Those reporting injecting in the four weeks preceding survey participation

Source: (Public Health England, 2015b)

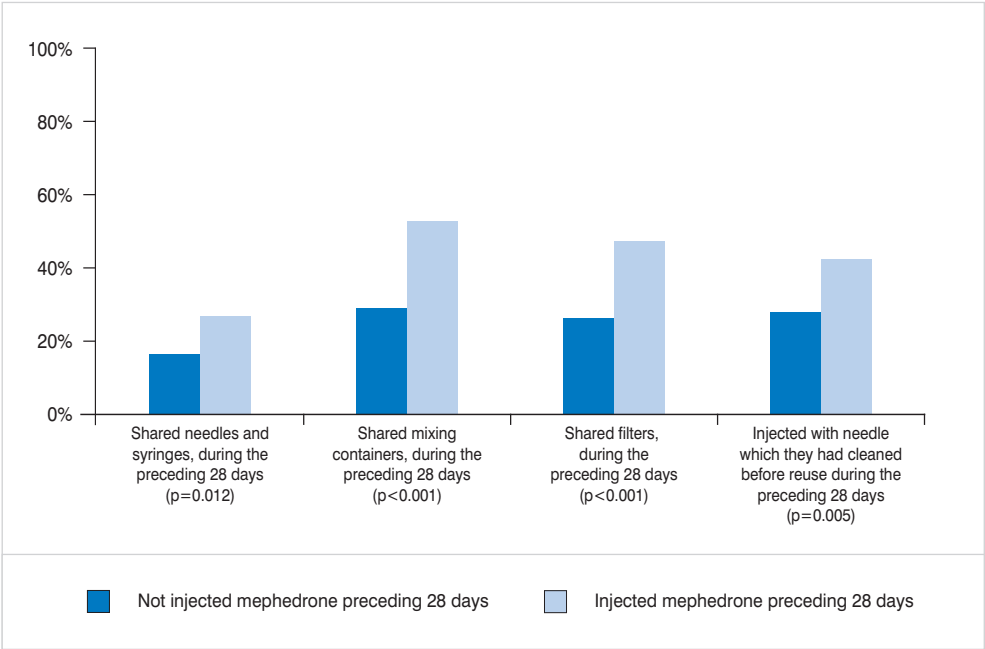
6.4.2 Sharing of injecting equipment: people who inject image and performance enhancing drugs

Among the participants in the 2012/13 UAM sub-survey of people who inject IPEDs, only 13% (95% CI, 9.3%-18%) reported ever sharing any injecting equipment (Public Health England, 2014f).¹⁰⁹ Sharing levels were slightly higher amongst those aged 25 to 34 years than amongst the other age groups in the 2013 sub-survey¹¹⁰ with 10% of those aged under 25 years reporting sharing compared with 16% of those aged 25 to 34 years and 12% of those aged 35 years and over (Public Health England, 2014b).

6.4.3 Sharing of injecting equipment: people who inject new psychoactive substances

There have been recent concerns about increased injection of stimulants, and in particular the emergence of the injection of new psychoactive substances (NPS), including mephedrone and other synthetic cathinones. These drugs are injected more frequently than opioids and compulsive re-dosing has been reported. In England, Wales and Northern Ireland, 5.9% of those surveyed as part of the UAM Survey in 2014 reported that they had injected mephedrone during the preceding month and 8.9% had injected this drug at some point during the preceding year. Those currently injecting mephedrone were more likely to report sharing needles, syringes and other injecting equipment than those currently injecting other substances

Figure 6.6: Injecting risk behaviours among those currently* injecting in England, Wales & Northern Ireland: 2014



Source: (Public Health England et al., 2015)

The recent cluster of Group A streptococci infections among PWID in the Edinburgh included those injecting the NPS ethylphenidate. The recent emergence of injection of this fairly short-acting stimulant probably played a role in the extent of this cluster, of often severe illnesses (see section 6.3.3). In south-west Wales, an increase in infections and other harms has been associated with the emergence of the injection of synthetic cathinones, including mephedrone. The changes in injection practice associated with the use of these stimulants probably markedly increased risk (Public Health England et al., 2015).

¹⁰⁹ Needle, syringe or vial

¹¹⁰ Age was not provided by all participants to the sub-survey

6.4.4 Condom use and sexual behaviour in people who inject drugs

In 2014, over two-thirds (68%, 95% CI, 66%-70%) of the PWID participating in the UAM Survey across England, Wales and Northern Ireland reported having anal or vaginal sex during the preceding year, and this level has changed little over time (Public Health England, 2015i). Of those who had sex in the last year, 40% (95% CI, 38%-42%) reported having had two or more sexual partners during that time. Of these individuals, only 22% (95% CI, 19%-25%) reported always using condoms for anal and vaginal sex. This suggests increased efforts are required to improve the use of condoms in PWID (Public Health England, 2015i).

Among the participants in the 2012/13 UAM sub-survey of people who inject IPEDs, nine-tenths (92%, 95% CI, 87%-95%) reported having anal or vaginal sex during the preceding year, suggesting this cohort are more sexually active than participants in the main UAM Survey of PWID (Public Health England, 2014b). Within the 92% of those who had sex in the previous year, 54% (95% CI, 47%-60%) reported having had two or more sexual partners during that time and of these, only 13%, (95% CI, 8%-21%) reported always using a condom; a smaller proportion than in the main UAM Survey of PWID (Public Health England, 2014f).

6.4.5 Men who have sex with men

There are on-going concerns about the injection of methamphetamine and mephedrone among some sub-groups of men who have sex with men (MSM), many of whom are HIV positive. These drugs are typically being used by these men during sex in a practice known as chemsex, with injecting equipment often shared while condoms are not always being used. Although the scale of this behaviour remains unclear, specialist Lesbian, Gay, Bisexual and Transgender (LGBT) drug services are continuing to see an increase in the number of MSM who report injecting these drugs. The use and injection of these drugs has also been reported to be a factor in the increased transmission of a number of sexually transmitted infections (STIs) (Bourne, Reid, Hickson, Torres Rueda, & Weatherburn, 2014; Kirby & Thornber-Dunwell, 2013).

The number of diagnoses of STIs reported in MSM has risen sharply in recent years. Recent figures show that syphilis diagnoses increased by 46% in the past year (2,375 to 3,477) and gonorrhoea diagnoses by 32% (13,629 to 18,029) (Public Health England, 2015e). Since 2009 there has been a steady increase in diagnoses of STIs in HIV-positive MSM, and the population rate of acute bacterial STIs is up to four times that of HIV-negative MSM or undiagnosed MSM. This pattern is indicative of rapid STIs transmission occurring in dense sexual networks of HIV-positive MSM (Malek et al., 2015). In addition, in recent years the number of new HIV diagnoses among MSM has increased steadily, rising from 2,860 men in 2010 to 3,360 men diagnosed HIV positive in 2014 (55% of all new diagnoses) (Public Health England, 2015g). This trend reflects both high levels of on-going HIV transmission and increases in HIV testing. There is also an increased risk of hepatitis C infection among MSM, which has been associated with having HIV and with chemsex. Data from the *Hepatitis C in the UK, 2015* report shows that newly acquired hepatitis C infection in England among MSM is on-going but declining. Among the HIV-positive MSM population transmission of hepatitis C is predominantly due to sexual transmission. In England the estimated incidence of infection in this population declined significantly over the four years up to 2013, and was 2.3 per 1,000 person years in 2013 (Public Health England, 2015f).

In November 2015 PHE published a briefing aimed at commissioners and providers of drug and alcohol services in order to highlight issues related to MSM and chemsex in particular. The document contains background information and recent data as well as case studies and prompts intended to support commissioners and providers of drug and alcohol services to meet the needs of MSM participating in chemsex (Public Health England, 2015i).

6.5 Other drug-related health correlates and consequences

6.5.1 Non-fatal overdoses and drug-related emergencies

The NHS Data Model and Dictionary defines an emergency admission as one that occurs *“when admission is unpredictable and at short notice because of clinical need”*. A drug-related acute emergency hence arises when medical care is sought while the patient is under the influence of drugs (not primarily alcohol). Based on this definition, data on drug overdoses and drug-related emergencies in the UK are provided using hospital inpatient data and International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) codes. However, it is difficult to assess the full extent of non-fatal overdoses and drug-related emergencies due to the use of illicit drugs. This is because the ICD-10 coding system includes some legally available drugs such as codeine, which can be purchased without prescription at pharmacies. Conversely, ICD-10 codes do not include NPS. Also, data from hospitals are only available for those who are admitted to hospital and stay as an inpatient. Evidence shows that less than one-third of individuals attending hospital with acute recreational drug toxicity are admitted to hospital, and even those admitted may not be assigned an appropriate ICD-10 code (UK Focal Point, 2011, 2014; Wood, Conran, & Dargan, 2011).

Discharge information is based on the patient's first episode within a continuous spell of treatment. A continuous inpatient stay is an unbroken period of time that a patient spends as an inpatient. In 2013/14, hospital inpatient data showed that there were 41,628 inpatient discharges recording poisoning by drugs in the UK, a nine per cent increase since 2012/13 (Table 6.1). As in previous years, over half (62.1% or 25,856) were due to 'other opioids including morphine and codeine'. Discharges linked to other opioid poisonings have increased each year from 2008/09 when there were 17,902. Heroin poisoning accounted for 7.7% (3,193) of discharges, cocaine for 6.7% (2,778) and methadone for 3.7% (1,527). Methadone poisoning discharges fell in 2013/14 to 1,527 from 1,543 in 2012/13 and from 1,833 in 2011/12. Almost all drug poisonings were emergencies (99%).

The latest *Global Drug Survey* 2015 revealed that for the third year running synthetic cannabinoids were more likely to leave people needing emergency medical treatment than any other drug group — with 3.5% of last year users reporting having sought emergency treatment in the last year (an increase from 2.5% the previous year). In the previous 12 months, 0.9% of respondents had sought emergency medical treatment after taking MDMA and one per cent after using cannabis (Global Drug Survey, 2015).

6.5.2 Enquiries to the National Poisons Information Service

The National Poisons Information Service (NPIS) is a service commissioned by PHE on behalf of the UK health departments. It provides information and advice for NHS healthcare professionals on the diagnosis, treatment and care of poisoned patients across the UK via its 24 hour telephone advice service and its online database TOXBASE®.¹¹¹ In order to provide better toxico-surveillance of drug misuse and a more comprehensive mechanism to describe recreational drug use, from 2014/15 the NPIS has changed its approach to the way telephone enquiries are recorded to capture all calls referring to drugs of misuse including prescription medicines, which are described as 'recreational' during the telephone enquiry.¹¹² These changes are aimed at facilitating the detection, monitoring and review of emerging substances that are causing clinical harm. Consequently, the telephone data reported here for 2014/15 cannot be directly compared to the data published in previous reports (Public Health England & National Poisons Information Service, 2015). In 2014/15, the NPIS reported 1,722 telephone enquiries related to 286 drugs of misuse. This represented 3.7% of all NPIS telephone enquiries. In the same year the NPIS also reported 69,537 online accesses on TOXBASE related to 598 drugs of misuse, representing 4.4% of all TOXBASE activity. For the 61 specific substances reported on in 2013/14, there was a 3.5% overall increase in telephone calls and a 6.7% increase in TOXBASE accesses in 2014/15. The most commonly accessed TOXBASE entries and subjects of telephone enquiries were stimulants including MDMA,

¹¹¹ See: <http://www.npis.org/toxbase.html>

¹¹² Until 2013/14 the NPIS provided data on telephone enquiries about 61 drugs of misuse. From 2014/15 that number has risen to 286 drugs of misuse

branded products¹¹³ and opioids. In relation to individual drug groups, when enquiries on synthetic cannabinoid receptor agonists (SCRAs) and branded products thought to contain these substances were combined, SCRAs registered the largest increase in telephone enquiries and TOXBASE accesses with a 144% and a 151% increase respectively compared to 2013/14 (Public Health England & National Poisons Information Service, 2015).

Table 6.1: Inpatient discharges recording poisoning by drugs in the United Kingdom, 2008/09 to 2013/14

DRUG	2008/09		2009/10		2010/11		2011/12		2012/13		2013/14	
	n	%	n	%	n	%	n	%	n	%	n	%
Other opioids including morphine and codeine	17,902	57.2	19,266	62.9	21,509	63.5	22,102	61.0	22,472	58.6	25,856	62.1
Heroin	3,053	9.8	3,155	10.3	2,500	7.4	2,453	6.8	2,338	6.1	3,193	7.7
Cocaine	2,627	8.4	1,986	6.5	2,247	6.7	2,139	5.9	2,226	5.8	2,778	6.7
Methadone	1,493	4.8	1,533	5.0	1,954	5.8	1,833	5.1	1,543	4.0	1,527	3.7
Total	31,319	100.0	30,618	100.0	33,889	100.0	36,255	100.0	38,342	100.0	41,628	100.0
Emergencies	30,991	99.0	30,311	99.0	31,794	93.7	35,897	99.0	37,908	99.0	41,178	99.0

Source: Personal communication – Public Health England, Department of Health, Social Services and Public Safety Northern Ireland, Information Services Division Scotland, Public Health Wales

6.6 Prevention and control of drug-related infectious diseases: harm reduction services

A range of services are provided across the UK that contribute to the prevention of infections amongst PWID. This section considers the key services involved in such prevention, other than OST and drug treatment, which are considered elsewhere (see section 5.5.6). Additionally, this section outlines the availability and uptake of diagnostic and treatment services for key infections.

Data indicate that the prevalence of HIV and hepatitis C infection among PWID in the UK has been broadly stable over the last decade, and the extent of current hepatitis B infection is very low and has probably declined over the last decade. These patterns reflect the extensive provision of interventions, such as needle and syringe programmes, and the increase in hepatitis B vaccination. Though service levels have been expanded or maintained over the last decade, further improvements to intervention coverage are probably needed. These will probably need to be sustained over many years if levels of hepatitis C, in particular, are to be reduced.

6.6.1 Needle and syringe programmes

Needle and syringe programmes (NSP) are provided throughout the UK in a variety of settings, principally through pharmacies and specialist services. These provide a range of injecting equipment and also advice on safer injecting practice. In addition, many offer other services including testing for BBVs, vaccinations, injection site care and referral into other specialist drug treatment and sexual health services. There are also a small number of mobile syringe exchanges, usually attached to a local treatment provider, and in Wales there is a single vending machine which can also be used to obtain syringes.

¹¹³ With this terminology NPIS refers to enquiries where the substances are difficult to classify because their chemical constituents are sometimes unknown and may change over time. It generally refers to the so-called 'legal highs'. Spice/synthetic cannabinoid data previously included branded products but, from 2014/15, these are now reported independently

In April 2014, the National Institute for Health and Care Excellence (NICE) updated its public health guidance *Needle and Syringe Programmes* (National Institute for Health and Care Excellence, 2014b). The new guidance makes recommendations on NSP, including those provided by pharmacies and drug services for adults and young people who inject drugs (including those under 16), with specific recommendations for users of IPEDs (for example, anabolic steroids for bodybuilding or injected tanning agents).

The vast majority (89%) of the participants in the UAM Survey of PWID from across England, Wales and Northern Ireland reported that they had used a NSP in 2014 (Public Health England, 2015b).

England

Data from the UAM Survey of PWID showed that in 2014 the vast majority (85%) of participants who injected psychoactive drugs in the previous year reported using a NSP, while only five per cent had never used a NSP (Public Health England, 2015f). Of those who had injected in the preceding four weeks, just under half (48%) reported receiving more needles than they required from a NSP¹¹⁴. Just less than one-third (29%) of participants who had injected in the preceding four weeks had injected with a used needle that they had attempted to clean. These findings may indicate that, in England, the majority of PWID are accessing NSP; however, equipment provision needs to be increased.

NSP are not currently provided in prisons. A recent audit of hepatitis C services in a representative sample of English prisons suggested that disinfection tablets for sterilising injecting equipment were available in 81% of English prisons. These tablets were accessed in a variety of ways: 53% of prisons made them available via dispensers, 41% of prisons distributed them directly via prison officers, and 12% of prisons distributed them via healthcare staff (Public Health England, 2015f).

Scotland

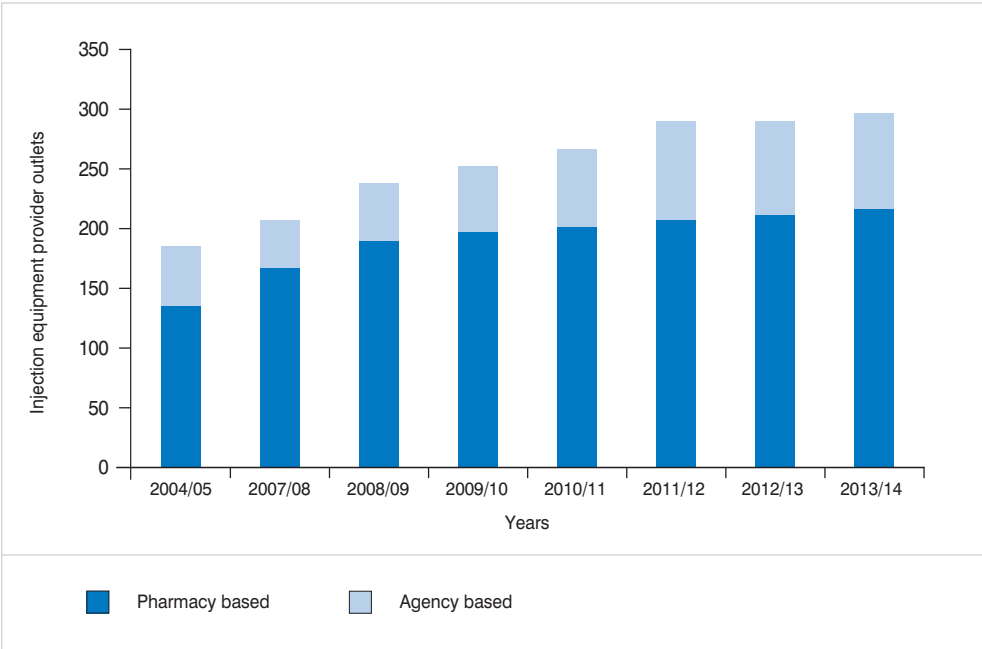
There were 299 injection equipment provider outlets, of which 218 (73%) were pharmacy-based, reported to be operating in Scotland in 2013/14. This is an increase from 188 outlets in 2004/05 (Figure 6.7).

Over four million needles/syringes¹¹⁵ were estimated to have been distributed to PWID in Scotland during 2013/14, based on data reported by 85% (255/299) of the injection equipment provider outlets. Accounting for the under-reporting in 2013/14, this is higher than the 3.6 million needles/syringes reported to have been distributed to PWID in Scotland during 2004/05, and similar to the number of needles/syringes (in the range 4.4 to 4.7 million per year) reported to have been distributed in recent years (2007/08 to 2012/13). The number of injecting paraphernalia items distributed to PWID has increased in recent years, with notable rises in the provision of filters and spoons/cookers between 2008/09 and 2009/10 and more recently in the provision of sterile water between 2012/13 and 2013/14. In 2013/14, the items distributed included: 2,864,000 filters, 2,810,000 spoons/cookers and 1,019,000 vials of sterile water.

¹¹⁴ This data should be interpreted with caution as some people receive more needles to pass to friends – known as secondary distribution

¹¹⁵ This estimate was calculated based on the data reported by 85% (255/299) of the injection equipment provider outlets. It will therefore not match data provided in ST10

Figure 6.7: Injection equipment provider outlets operating in Scotland between 2004/2005 and 2013/2014



Source: (Public Health England, 2015f)

Wales

The provision of NSP, and other harm reduction services, in Wales is monitored using the Harm Reduction Database (HRD). In 2014/15 the HRD was active in 47 statutory and voluntary sector NSP sites across Wales, including five mobile services and four hostels. The 207 community pharmacies providing NSP services were linked to the HRD in April 2014 (Public Health England, 2015f). Data from the HRD indicates a total of 25,409 unique individuals accessed NSP services (including community pharmacy) from April 2014 to March 2015 (Public Health England, 2015f). Of these, 51% reported primary use IPEDs; 37% opioids; 9.4% stimulants (crack, amphetamine, etc.); and 1.5% new psychoactive substances (NPS) (Public Health England, 2015f).

In 2014/15 a total of 3,141,442 syringes were distributed in Wales. Fifty-four per cent ($n = 1,693,980$) of syringes were distributed through pharmacy-based NSP, whilst specialist agencies distributed 46% ($n = 1,446,280$) and 1,182 were accessed through a syringe vending machine ($>1\%$) (ST10).

In specialist agencies there were 9,725 unique clients who generated 47,626 client contacts, and pharmacy-based NSP distributed to 18,593¹¹⁶ clients over 87,314 transactions (ST10). The primary drug type profile of those accessing NSP via specialist agencies was: 45% IPED; 43% opioid users; 8.3% stimulants (crack, amphetamine etc.); and 2.1% NPS. Amongst people who had injected psychoactive drugs (all substances excluding IPEDs), 80% were male (Public Health England, 2015f).

¹¹⁶ Due to multi-site access the total number of unique NSP clients accessing either or both specialist and pharmacy based services is 25,409 clients.

In Northern Ireland, NSP were available in 18 locations, including three outreach services. The number of packs dispensed by needle exchange schemes has increased year-on-year since 2007/08, reaching 28,284 in 2013/14. Specific packs are available for people who inject IPEDs and the number of packs issued for this use is rising (Public Health England, 2015f). In 2013/14, of the 15,483 visits to the NSP where the person disclosed what they would use the needles for, 58% were for injecting IPEDs (Public Health England, 2015f). In 2013/14 there were 241,370 needles distributed during 22,742 client contacts, predominantly (98%) through pharmacy-based NSP and the remaining two per cent via specialist agencies.

6.6.2 Hepatitis B vaccination

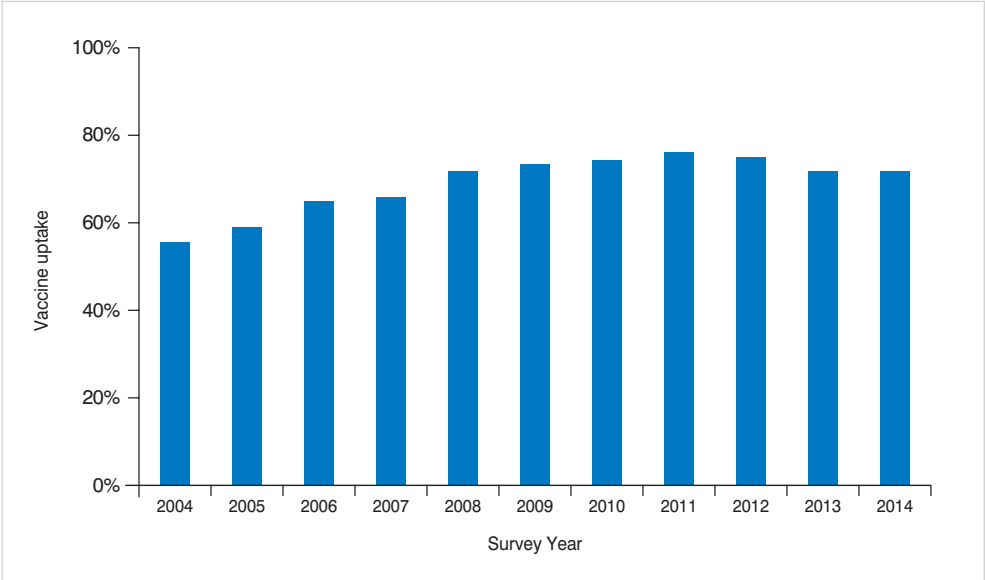
Hepatitis B is a vaccine-preventable infection that can cause long-term liver disease and liver cancer. The UK has a targeted vaccination programme focused on the population groups most at risk, including PWID.

The proportion of the PWID participating in the UAM Survey who reported having taken up an offer of the hepatitis B vaccination has increased markedly over time, rising from 56% (95% CI, 54%-58%) in 2004 to 76% (95% CI, 75%-78%) in 2011. In 2014, uptake had dropped slightly to 72% (95% CI, 71%-74%; self-reported data) (Public Health England, 2015l) (Figure 6.8). Uptake of hepatitis B vaccination was comparable in England, Wales and Northern Ireland, (range: 72%-78%).

Among the participants in the 2012/13 sub-survey of people who inject IPEDs, the level for uptake of the hepatitis B vaccination was lower, with 40% (95% CI, 34%-47%) of those injecting IPEDs reporting this compared to 76% (95% CI, 75%-78%) of those in the main UAM Survey sample of people injecting psychoactive drugs (Public Health England, 2014f).

In Scotland, among those attending needle and syringe programmes during 2013/14, 74% reported uptake of the hepatitis B vaccine (Public Health England, Health Protection Scotland, Public Health Wales, & Public Health Agency Northern Ireland, 2014; Public Health England et al., 2015).

Figure 6.8: Uptake of hepatitis B vaccination amongst participants in the Unlinked Anonymous Monitoring Survey of People Who Inject Drugs: England, Wales and Northern Ireland, 2004-2014



Source: (Public Health England, 2015l)

6.6.3 Hepatitis C diagnosis and treatment

In the UK, public health programmes related to hepatitis C focus on four key action areas: prevention of new infections; increasing awareness of infection; increasing testing and diagnosis; and getting diagnosed individuals into treatment and care.

Hepatitis C prevention strategies primarily focus on injecting drug use, as this is presently the most important risk factor for acquisition of the virus in the UK. Reducing the number of individuals who begin injecting drugs, encouraging injectors to stop injecting, reducing risky behaviour, such as sharing needles and syringes, in those who continue to inject, and the early diagnosis and treatment of those who become infected with hepatitis C, are all components of the prevention programme.

Data from the UAM Survey of people who inject psychoactive drugs in England, Wales and Northern Ireland shows a significant increase over the past decade in the self-reported uptake of voluntary confidential testing (VCT) for hepatitis C among survey participants, with the proportion of survey participants ever tested rising from 67% (95% CI, 65%-69%) in 2004 to 82% (95% CI, 80%-83%) in 2010. The level has been stable since then and was 83% (95% CI, 82%-85%) in 2014 (Public Health England, 2015l). This stabilisation may suggest that there is saturation among the pool of easy-to-access individuals and/or a reduction in awareness raising activity.

The proportion of participants who answered the questions on the uptake of VCT for hepatitis C, reporting that they were aware of their hepatitis C infection was 52% (95% CI, 50%-55%) in 2014. This indicates that around half of the hepatitis C infections in this population remain undiagnosed. However, this varied across England, Wales and Northern Ireland (Table 6.2) (Public Health England, 2015l).

Table 6.2: Uptake of voluntary confidential testing for hepatitis C and the proportion of clients aware of hepatitis C infection in England, Wales, Northern Ireland and combined, 2014

	UPTAKE OF HEPATITIS C VOLUNTARY CONFIDENTIAL TESTING	PROPORTION AWARE OF HEPATITIS C INFECTION
England	83%	52%
Wales	85%	48%
Northern Ireland	88%	68%
England, Wales and Northern Ireland	83%	52%

Source: (Public Health England, 2015b)

Among the participants in the 2012/13 sub-survey of people who inject IPEDs, 32% (95% CI, 26%-38%) reported ever having a VCT for HCV (Public Health England, 2014b). The reported level of the uptake of VCT for HCV in this group was much lower than that reported among participants in the main survey of people who inject psychoactive drugs in the same year (82%, 95% CI, 81%-84%).

In Scotland, among 2,331 PWID interviewed at services providing injection equipment during 2013/14, 88% reported having been tested for hepatitis C in the past with 45% having been last tested during the previous year (Public Health England, 2015f). When those who reported a previous hepatitis C diagnosis (prior to 12 months ago) were excluded, the percentage of respondents who had been tested for hepatitis C during the last year has been steadily increasing and was 52% in 2013/14 compared to 40%, 45% and 49% in 2008/09, 2010 and 2011/12 respectively (Public Health England, 2015f).

Across the UK, alternative testing technologies, in particular the use of dried blood spot (DBS) testing, are continuing to contribute to the increased uptake of hepatitis C testing among PWID. In England Sentinel surveillance data indicate that the number of people tested by venepuncture has fallen by 25% between 2013 and 2014 whereas the rate of DBS testing has increased by 23% during that period (Public Health England, 2015f). In Wales, in individuals thought to have been tested via Substance Misuse

Services or in prisons, it is estimated that the numbers tested via DBS increased by 12% between 2012 and 2013 with over 1,800 individuals tested in 2013; there were over 1,600 DBS tests undertaken in these settings in Wales during 2014.

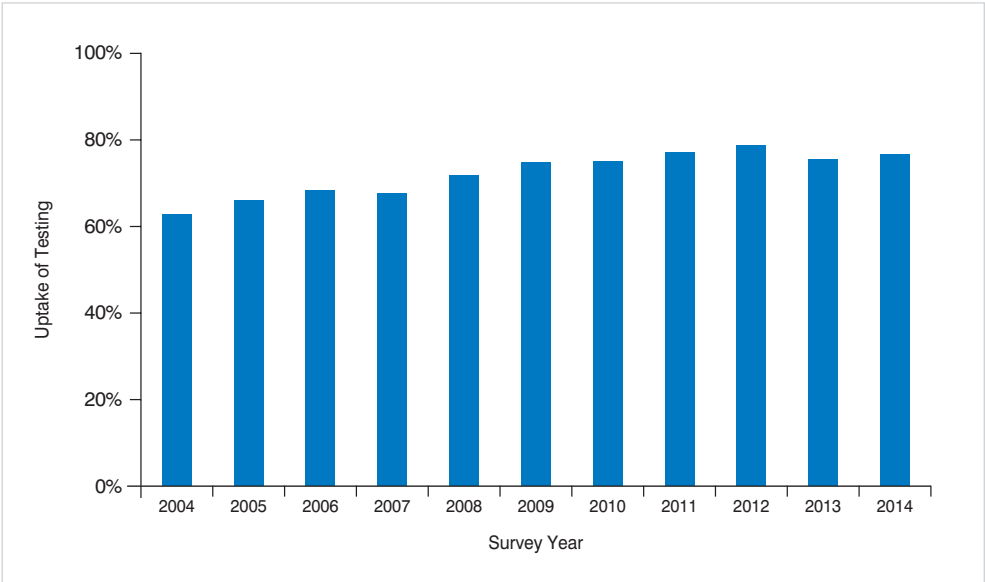
Mathematical modelling work indicates that successfully treating hepatitis C infections among PWID, alongside provision of NSP and drug treatment services, could reduce transmission of hepatitis C and so harm. Among the participants from the UAM Survey of PWID who had received a positive diagnosis and were aware of their hepatitis C status, 69% in England and 73% in Wales reported that they had seen a specialist doctor or nurse about their infection (Public Health England, 2015f). Of the English participants, 18% reported receiving any kind of medication related to their infection.

Data collection systems to provide information on the numbers of individuals commencing treatment for hepatitis C infection have been under development in Wales. It is estimated that in 2011 and 2013 over 700 individuals commenced treatment (Public Health England, 2015f). In England ways of monitoring numbers being treated are being developed. Although there is much uncertainty, the current available data suggest that over 4,000 people with hepatitis C are being treated each year (Public Health England, 2015f). The number of chronically infected people who began hepatitis C antiviral therapy in Scotland increased to 1,273 in 2014/15 (Public Health England, 2015f). For Northern Ireland the available data, collected from the Regional Hepatology Unit in Belfast, indicate that since January 2004, 420 people have commenced treatment for hepatitis C (Public Health England, 2015f).

6.6.4 HIV diagnosis and treatment

Amongst PWID, the self-reported uptake of VCT for HIV among the UAM Survey of PWID which recruits across England, Wales and Northern Ireland has increased significantly since 2004; 63% (95% CI, 61%-65%) in 2004 to 77% (95% CI, 75%-78%) in 2014 (Figure 6.9) (Public Health England, 2015l). In 2014, VCT was comparable across genders; 76% of males and 79% of females self-reported testing. Sixty-three per cent of those under 25 self-reported VCT compared to 74% of those aged 25-34 and 79% of people over 35 years of age. In 2014, of the participants in the UAM Survey who had antibodies to HIV, 85% (95% CI, 66%-94%) reported awareness of their infection.

Figure 6.9: Uptake of voluntary confidential HIV testing amongst participants in the Unlinked Anonymous Monitoring Survey of people who inject drugs: England, Wales and Northern Ireland, 2004-2014



Source: (Public Health England, 2015l)

In Scotland, among those attending needle and syringe programmes during 2013/14, 78% reported having ever had a VCT for HIV. In 2008-09, 68% of those surveyed in Scotland had reported uptake (Public Health England et al., 2014).

Among the participants in the 2012/13 sub-survey of people who inject IPEDs (Public Health England, 2014c), 41% (95% CI, 35%-47%) reported ever having a VCT for HIV which is significantly lower than self-reported levels in the main UAM Survey of people who inject psychoactive drugs (76%, 95% CI, 74%-78%).

The number of HIV-infected people seen for HIV treatment and care in the UK who had acquired their infection through injecting has increased over the past decade, with 1,654 seen in 2014 (Public Health England et al., 2014). In 2014, 418 people who acquired their HIV-infection through injecting, and who were seen for care, had CD4 counts of 350 cells/mm³ or less (the recommended level to start anti-retroviral therapy). Among those seen for HIV treatment and care with CD4 counts of 350 or less in 2014, 87% of those who had acquired their infection through injecting were on anti-retroviral therapy, this is similar to the level found in other groups. Following revision to the guidelines in 2015, anti-retroviral treatment is now recommended for all those with HIV; in 2014, 90% of those seen for care who had acquired their HIV infection through injecting drug use were on anti-retroviral therapy.

6.7 New developments

6.7.1 Scotland

In September 2015 new clinical guidelines for the treatment of HCV in adults were published (Dillon, Hayes, Barclay, & Fraser, 2015). Developed in collaboration with Health Improvement Scotland and NHS Scotland, the guidelines provide recommendations to Health Boards, Area Drug and Therapeutics Committees and clinicians regarding the efficacy of available drugs for treating the different genotypes of HCV. The guidelines also take the cost of different drugs into account and recommend the most cost-effective regimen where efficacy is not statistically different. This is to ensure that the maximum number of patients can be treated.

6.7.2 Wales

Liver Disease Delivery Plan for Wales (2015-20)

In May 2015 Welsh Government published their new Together for Health – Liver Disease Plan which will succeed the existing Blood Borne Viral Hepatitis Action Plan for Wales. Encompassing liver disease relating to alcohol, obesity and viral hepatitis, the liver disease plan sets out Wales' on-going key service issues, priorities and assurance measures in preventing disease and improving treatment services. The plan is split into six key themes:

- preventing liver disease and promoting liver health;
- timely detection of liver disease;
- fast and effective care;
- living with liver disease;
- improving information; and
- targeting research

The plan calls for partnership working across the NHS and the wider public and voluntary sectors; moreover, it requires Health Boards to develop liver disease plans and to report progress on an annual basis to ensure delivery of the desired aims.

6.7.3 Northern Ireland

In Northern Ireland a pilot project is being undertaken during 2015 in some pharmacy needle exchange sites to survey people using IPEDs. This survey will involve unlinked anonymous survey methodology, using a subject-completed questionnaire and collection of a DBS for BBV testing. It aims to provide a greater insight into risk and harm among individuals who use IPEDs in Northern Ireland.

7. Drug-related deaths

7.1 Introduction

Data on drug-related deaths submitted to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) by the United Kingdom (UK) are based on three different definitions. The EMCDDA definition refers to deaths caused directly by the consumption of at least one illicit drug.¹¹⁷ The UK Drug Misuse Definition (DMD),¹¹⁸ originally adopted to measure the impact of the former UK Drug Strategy (Home Office, 2002), is where the underlying cause is drug abuse, drug dependence, or poisonings where any of the substances scheduled under the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971) are involved. The definition used by the Office for National Statistics (ONS) is much wider and includes legal drugs.¹¹⁹

There are three General Mortality Registers (GMRs) in the UK: figures for England and Wales are both reported through a single GMR held by ONS. Due to this, combined figures for England and Wales are routinely reported in this chapter. It should be noted that trends may differ between the two countries as well as between regions within each country.

The UK DMD has been adopted by the GMRs across the UK and is a subset of the ONS definition. Information on deaths is also available from a Special Mortality Register (SMR).¹²⁰

In the UK, based on the DMD, the number of deaths registered increased each year from 2004 ($n = 1,932$) to a peak in 2008 ($n = 2,607$). This was followed by year on year decreases in the number of drug-related deaths between 2008 and 2012. However, over the last two years there has been an increase of almost 30% from 2,283 deaths registered in 2012 to 2,936 in 2014. Among deaths where heroin was mentioned on the death certificate, there has been a long-term trend towards other substances (including alcohol) being mentioned alongside heroin, and away from heroin being the only drug mentioned.

There has been growing concern regarding the harmful effects of new psychoactive substances (NPS) across the UK. In March 2015 the synthetic stimulant 4,4'-dimethylaminorex (4,4'-DMAR) became controlled as a class A drug after it was associated with 37 deaths across the UK. The Prisons and Probation Ombudsman (PPO) also reported on an increased number of deaths in prison related to NPS between April 2012 and September 2014 (Prisons and Probation Ombudsman, 2015).

7.2 Drug-related deaths and mortality of drug users

7.2.1 Changes to methodology

In England and Wales, there are significant delays in registration of drug-related deaths - as of 2014, the median delay was between five and six months. Scotland is subject to different legislation around registration of deaths and experiences only minimal delays. This is problematic for reporting figures based on registration year at UK level, as this combines up-to-date data from Scotland with generally delayed data from England and Wales. Consequently, UK figures under the EMCDDA definition are, from 2015 reporting year onwards, counting deaths from England and Wales according to year of occurrence. As such, 2013 is the latest available reporting year by this definition, as this is the most recent year where it can be assumed that the large majority of relevant deaths in England and Wales have now been registered (it is probable that a substantial proportion occurring in 2014 were not registered by the end of 2014). For the ONS and DM definitions, the figures continue to represent registrations in the most recent year (2014).

¹¹⁷ These deaths are known as 'overdoses', 'poisonings' or 'drug-induced deaths'. See: <http://www.emcdda.europa.eu/themes/key-indicators/drd>

¹¹⁸ Formerly known as the Drug Strategy Definition (DSD) and originally adopted to measure progress against an aim in a former UK Drug Strategy (Home Office, 2002).

¹¹⁹ For ONS definitions See: ONS (2013) <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-314585>

¹²⁰ The National Programme on Substance Misuse Deaths (NPSAD) publishes data from inquests into drug-related deaths reported by coroners in England, Wales, Northern Ireland, Guernsey, Jersey and the Isle of Man; Procurators Fiscal in Scotland and the Scottish Crime and Drug Enforcement Agency (SCDEA).

A further methodological change in this year's reporting is that deaths with an underlying cause of death recorded as the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) codes X44, X64 or Y14 alongside relevant T-codes have been incorporated into UK figures reported using the EMCDDA definition. Due to historical coding practice in England and Wales, this has substantially increased the number of deaths counted under this definition. Also, due to changes in reporting, the small number of deaths registered in England and Wales where the person was not resident in either country are no longer included. For each definition, the time series back to 2004 has been updated to take into account these changes (see ST06).

7.2.2 Overdose deaths

Using the EMCDDA definition, the total number of drug-related deaths occurring in the UK during 2013 was 2,449, a 12% increase from 2012 ($n = 2,178$) (ST06) and the highest number reported to date. Using the slightly different definition of drug misuse, and reporting based on year of registration, there were 2,936 drug-related deaths registered in the UK in 2014 (up from 2,551 in 2013). Using the much wider ONS definition, there were 4,174 drug-related deaths registered in the UK in 2014 (up from 3,742 in 2013).

Overdose deaths recorded in each General Mortality Register

In 2013, a total of 1,868 drug-related deaths were reported under the EMCDDA definition for England and Wales – this is 76% of the UK total. In Scotland, 516 deaths (21%) were reported and 65 (3%) for Northern Ireland. The combined England and Wales total saw an 18% increase in the number of drug-related deaths compared to 2012, while Scotland experienced a fall of 6%, and Northern Ireland a rise of 48%. As a result, deaths from England and Wales make up a greater proportion of the UK total than in 2012 (up from 73%) and deaths from Scotland a smaller proportion (down from 25%).

Age and gender

Of the deaths occurring in 2013 meeting the EMCDDA definition, almost three-quarters (74%, $n = 1,812$) were males and one-quarter ($n = 637$) were females (ST05). This proportion is similar across the UK, ranging from 72% males in Northern Ireland to 75% males in Scotland. The number of deaths amongst males in the UK has increased by 14% between 2012 and 2013 and by 7% amongst females.

In 2013, the average age of those dying was 41.6 years, with males tending to be about five years younger than females (40.5 years and 45.1 years respectively). The average age at death has increased from 37.6 years in 2004. The average age was lower in Scotland than for the UK as a whole (40 years), particularly for women (42 years).

Overall, the largest proportion of deaths occurring in the UK in 2013 occurred in the 40 to 44 years age group (433, or 18% of deaths) and deaths in this age group increased by 21% from the previous year ($n = 358$). Compared to 2008, the number of drug-related deaths decreased for all age groups below the age of 40 and increased for all age groups above this point. An increase was seen in all age groups in 2013 compared to 2012, with the exception of the 20-24 years age group.

Intentionality

Three-quarters of deaths reported in the UK using the EMCDDA definition for 2013 (72%, 1,769 deaths) were accidental self-poisonings (ST05). There were 268 deaths reported as intentional self-poisonings and 270 deaths as poisonings of undetermined intent (11% each). The remaining six per cent of deaths are reported as mental and behavioural disorders due to psychoactive substance use ('F' codes). A higher proportion of deaths are reported as 'undetermined intent' in Scotland than in England and Wales (17% vs nine per cent), and a much higher proportion again in Northern Ireland (35%). Northern Ireland also has a higher proportion of deaths reported using the 'F' codes than the UK as a whole (18%), with only 28% reported as accidental poisonings.

7.2.3 Toxicology of overdose deaths

Headline figures for the United Kingdom

Across the UK under the EMCDDA definition for 2013, there were 2,160 deaths counted which featured an opioid (ST05). This was 88% of the UK total. Ten per cent involved non-opioid drugs without an opioid, while two per cent of the total did not have any drug specified. The proportion with opioid use has remained broadly similar since 2004 (ST06), while the proportion with non-opioid drugs without an opioid has risen from six per cent. The proportion with no drug specified has fallen from six per cent.

The proportion of deaths featuring an opioid reported through each GMR in 2013 was highest in Scotland (93%), followed by Northern Ireland (91%), with England and Wales lowest (87%). Almost all cases with no drug specified were in England and Wales, where 11% featured non-opioid drugs without an opioid.

Table 7.1: Mentions of selected drugs on death certificates, England and Wales 2004 to 2013 (EMCDDA definition)

	DATE OF DEATH YEAR									
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
All EMCDDA def	1706	1739	1684	1911	1788	1865	1537	1597	1586	1868
Opioids	1475	1467	1384	1581	1503	1636	1360	1427	1368	1624
Heroin	799	782	777	894	798	909	609	559	608	792
Methadone	204	231	290	349	399	375	401	490	392	366
Tramadol	14	29	20	28	37	37	84	163	178	237
Cocaine	151	186	181	231	214	156	108	120	138	174
Amphetamines	86	96	92	102	94	48	57	78	114	126
Ecstasy	51	46	48	50	39	4	9	25	40	37
Benzodiazepines	140	125	128	164	184	245	216	248	244	287
Opiates %	86%	84%	82%	83%	84%	88%	88%	89%	86%	87%
Heroin %	47%	45%	46%	47%	45%	49%	40%	35%	38%	42%
Methadone %	12%	13%	17%	18%	22%	20%	26%	31%	25%	20%
Tramadol %	1%	2%	1%	1%	2%	2%	5%	10%	11%	13%
Cocaine %	9%	11%	11%	12%	12%	8%	7%	8%	9%	9%
Amphetamines %	5%	6%	5%	5%	5%	3%	4%	5%	7%	7%
Ecstasy %	3%	3%	3%	3%	2%	0%	1%	2%	3%	2%
Benzodiazepines %	8%	7%	8%	9%	10%	13%	14%	16%	15%	15%

Source: ST05

Detail of substances mentioned/implicated from each General Mortality Register within the United Kingdom

Each of the three GMRs in the UK are subject to annual reporting which reports by substances mentioned or implicated in greater detail than is currently available at UK level.

England and Wales

The most recent figures for England and Wales cover 2014 registrations (Office for National Statistics, 2015) reported using the DMD and the broader ONS definition. There were 952 registrations of deaths where heroin/morphine was mentioned, which represented a 24% increase on registrations in 2013 and a 64% increase from 2012 (however, deaths registered in 2011 to 2012 were notably lower than the preceding years). Heroin/morphine deaths accounted for 45% of deaths under the DMD, and heroin was the only drug mentioned in 23% of drug misuse deaths (492 deaths). Methadone was mentioned in 394 cases (19%), which was a similar number to the previous two years and lower than a peak of 486 in 2011. Methadone was the only drug mentioned in 132 deaths (six per cent of the total). Tramadol, which recently became a controlled drug within the UK (UK Focal Point, 2013), accounted for 240 deaths (11%), the highest number reported to date and an increase of nine per cent on 2013. In total, 1,786 deaths featured at least one opioid, disregarding those included as part of a paracetamol compound.

Benzodiazepines were mentioned in 372 deaths registered in 2014 in England and Wales, 18% of the total under the DMD, and an increase of nine per cent on 2013. However, only 22 of these cases did not also mention another drug. Cocaine was mentioned in 247 deaths (12%), an increase of 46% on 2013. Similarly, the number of mentions of amphetamines rose to 151 (seven per cent of deaths), a 26% increase on 2013. For both cocaine and amphetamines, the number of mentions in deaths was more than double that reported in 2011. Mentions of NPS continued to rise, increasing slightly to 67 (three per cent of deaths), although ONS noted that analysis of the trends based on the year the death occurred suggested that NPS deaths fell in 2013 after successive rises in 2011 and 2012. The majority of NPS deaths were accounted for by mentions of cathinones (principally mephedrone) and GHB/GBL. Around one-third of deaths registered in 2014 where at least one opioid was mentioned also had a mention of alcohol (576 deaths, 32%), rising to 36% for deaths where heroin/morphine or methadone were mentioned.

When broken down by substance, there were distinct differences in the age profile among deaths registered in England and Wales in 2014. The majority of deaths where NPS, cocaine or amphetamine were mentioned occurred in people under 40 years of age, while the reverse was true for deaths where opioids or benzodiazepines were mentioned.

Scotland

Statistics for drug-related deaths in Scotland registered in 2014 were published in August 2015 (National Records of Scotland, 2015). For this report, drug-related deaths are identified by National Records of Scotland (NRS) requesting further information on all deaths involving drugs or persons known, or suspected, to be drug-dependent, or where the information on the death certificate is vague or suggests that there might be a background of drug abuse. This corresponds closely to the UK drug misuse definition. There were 613 such deaths registered in Scotland in 2014.

In 2014, there were 535 deaths in Scotland where an opioid was implicated. This was 87% of all drug-related deaths, an increase of 16% on 2013 (461 deaths). In 209 of these cases, only opioids (and possibly alcohol) were implicated in the death. Within the opioid category, heroin/morphine was the most commonly implicated drug, with 309 deaths (50% of all deaths), followed by methadone with 214 deaths (35%). Deaths where heroin/morphine was implicated increased by 40% in 2014 rising from 221 in 2013. Benzodiazepines were implicated in 121 deaths in 2014 (20%), falling by 38% from 2012. Cocaine was implicated in seven per cent of deaths, with ecstasy and amphetamines, reported distinctly, at two and four per cent respectively. Alcohol was implicated in 106 drug-related deaths (17%). NPS were implicated in 62 cases; benzodiazepine-type NPS were the only NPS present. There were only seven cases where NPS were implicated without any other substance.

Tables for drug-related deaths registered in 2014 in Northern Ireland were published in September 2015.¹²¹ These are reported according to the DMD and ONS definitions. In contrast to the rest of the UK, benzodiazepines were the most commonly mentioned substance group, being mentioned in 45 deaths registered in 2014 (51% of deaths counted under DMD) and 365 deaths registered between 2004 and 2014 (59%). Again in contrast to the UK as a whole, tramadol was the most commonly mentioned opioid drug, in 22 deaths registered in 2014 (25%), followed by codeine (excluding compounds), mentioned in 20 deaths (23%). Heroin/morphine was mentioned in 11 deaths (13%).

7.2.4 Mortality cohort studies

Pierce et al. carried out a national record linkage study of 198,247 opioid users in England identified via drug treatment and criminal justice sources between April 2005 and March 2009, linking to mortality records (Pierce, Bird, Hickman, & Millar, 2015). They identified 3,974 deaths from all causes within the cohort, a rate almost six times what would be expected in a sample of the general population with the same distribution age and gender (standardised mortality ratio of 5.7, with 95% confidence intervals (CI): 5.5-5.9). Of these deaths, 1,715 (43%) were drug-related poisonings. The authors found that risk of drug-related poisoning was greater for males than females (crude mortality rate of 35 per 10,000 person years (PY) for men compared to 23 for women), that risk increased with age, and that the difference in risk between males and females narrowed considerably with age. The study also found that the opioid users in the cohort were at elevated risk of mortality from other causes of death, including infectious disease, respiratory disease, circulatory disease, liver disease, suicide, and homicide.

In a follow-up study, 151,983 opioid users treated for opioid dependence in England between April 2005 and March 2009 were identified in order to assess risk of drug-related poisoning (DRP) (Pierce, Bird, Hickman, Marsden, et al., 2015). Differences in risk were considered according to the type(s) of treatment received, as well as modifying factors such as patient characteristics, route of referral, and treatment completion. The study found that there were 1,499 DRP deaths in the cohort, a rate of 3.4 per 1,000 PY (with 95% CI: 3.2-3.6). Risk when enrolled only in a psychological intervention was found to be double that observed during periods receiving opioid agonist pharmacotherapy with or without psychological support (adjusted hazard ratio of 2.07, with 95% CI: 1.75 to 2.46). Increased risk of DRP death outside of treatment was greater for: men; illicit drug injectors; and those reporting problematic alcohol use.

White et al. carried out a longitudinal cohort study which explored risk of opioid poisoning in relation to periods of treatment for opioid use in England (White et al., 2015). This study used a counterfactual model which used estimated annual prevalence of opioid use, treatment data and mortality data to establish risk of opioid poisoning prior to treatment, during treatment and after treatment. It was then possible to estimate the number of opioid poisonings prevented by treatment. The authors found that 220,665 opioid users had been in treatment in England at some time between April 2008 and March 2011. There were 741 opioid poisonings during treatment, a rate of 0.2 per 100 PY, increasing to 0.4 per 100 PY after treatment (268 deaths). Prior to treatment the risk was higher still at 0.8 per 100 PY (2,722 deaths). Using a counterfactual method, the authors estimated that an average of 880 opioid poisonings (with 95% CI: 702 to 1,084) were prevented by treatment services in England annually.

Bird et al. (2015) explored the impact of Opioid Substitution Treatment (OST) provided to prisoners in Scotland on drug-related death risk following prison release (Bird, Fischbacher, Graham, & Fraser, 2015). The study found that between 1996 and 2002, prior to the introduction of prison-based OST, there were 305 drug-related deaths in the 12 weeks following prison release, a rate of 3.8 per 1,000 prison releases (with 95% CI: 3.4-4.2), with 145 occurring in the first 14 days. Between 2003 and 2007, after the introduction of prison-based OST, this rate fell to 2.2 per 1,000 prison releases (154 deaths; with 95% CI: 1.8 to 2.5). Whilst the overall rate of Drug-Related Deaths (DRD) was significantly decreased, the proportion that occurred within 14 days post release did not appreciably change.

¹²¹ See: <http://www.nisra.gov.uk/demography/default.asp30.htm>

7.3 Trends in drug-related deaths

7.3.1 Short-term trends

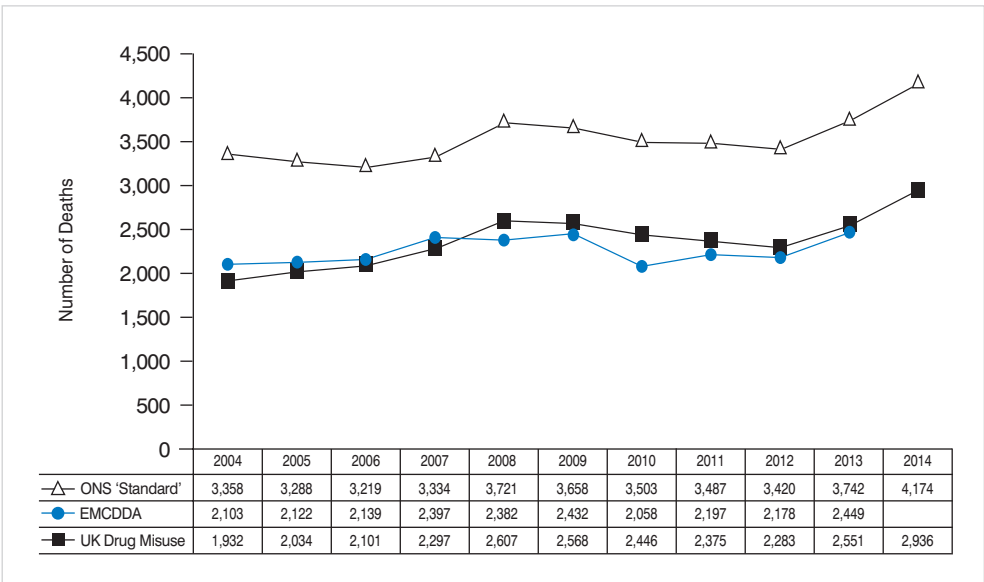
Using the revised figures under the EMCDDA definition, the figure of 2,449 drug-related deaths in 2013 is the highest to date for the UK, exceeding the previous peak of 2,432 in 2009 (ST06). Due to the registration delays in England and Wales, the 2013 figure will be revised slightly upwards when the UK reports to the EMCDDA in 2016. Following the previous peak in 2009, there was a sharp fall in drug-related deaths in 2010 (to 2,058, a decrease of 15% from 2009), with a small rise in 2011, a stable figure in 2012, and the increase of 12% observed for 2013.

It should be noted that figures for 2014 based on using year of registration indicate that the large increase in drug-related deaths in the UK for 2013 is very likely to have been followed by a further significant increase in 2014. This is evident in the figures submitted for the UK for 2014 registrations using the DMD, which show a 15% increase in registrations from 2013, and a 29% total increase from 2012. Figures published by ONS for England and Wales for 2014 registrations (Office for National Statistics, 2015) show a 15% increase using the DMD from 2013 and a 37% increase from 2012. In Scotland, where the registration delays are minimal and therefore registration year essentially equates to year of death, there was a reported 16% rise in 2014, to 613 deaths (National Records of Scotland, 2015). There is also an increase of 15% in deaths registered in Northern Ireland using DMD in 2014, to 90 deaths. It is therefore safe to conclude, with all the available information, that the increase reported for the UK for 2013 probably represents the start of an increasing trend. However, ONS figures suggest that Wales may be an exception to the UK trend, with a reported 16% fall in deaths registered using DMD in 2014.

7.3.2 Long-term trends

The GMRs for England & Wales and Scotland have reported figures going back to deaths registered in 1993 and 1996 respectively. Figure 7.1 shows the trend from 2004 onwards using each definition. It should be noted that with the change to report by year of occurrence for the EMCDDA definition this now differs from the other two definitions which continue to be reported by year of registration. This can cause divergence between the definitions in individual years, such as in 2010 where a large fall can be observed in the EMCDDA definition which is less pronounced in the other definitions.

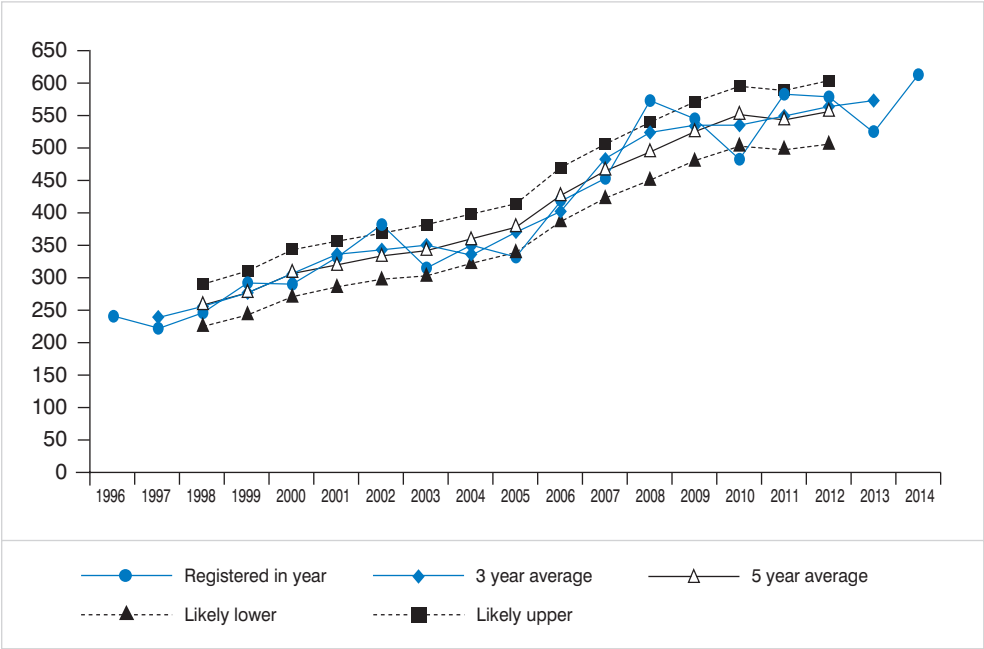
Figure 7.1: Drug-related deaths in the United Kingdom, 2004 to 2014 by definition



Source: ST06

In Scotland, there has been a general increasing trend in drug-related deaths since reporting began in 1996 (National Records of Scotland, 2015). Figure 7.2 shows the annual figures, along with 3- and 5-year moving averages, to provide a better indication of the overall long-term trend.

Figure 7.2: Drug-related deaths registered in Scotland, 3- and 5-year moving averages, and likely range of values around 5-year moving average, 1996-2014



Source: National Records of Scotland, 2015

7.4 Complementary sources of data

7.4.1 National Programme on Substance Abuse Deaths (England, Northern Ireland, the Channel Islands and the Isle of Man)

The National Programme on Substance Abuse Deaths (NPSAD) published their most recent report in September 2015 (Claridge & Goodair, 2015). This report covered drug-related deaths in England, Northern Ireland, the Channel Islands and the Isle of Man, occurring in 2013. Unlike previous NPSAD reports, Scotland and Wales are not within the scope of the report. The NPSAD report is based on a specific definition which may include deaths that are not normally within the scope of the drug misuse definition (DMD). Figures are also reported against the DMD used across the UK. NPSAD are notified of relevant deaths by coroners, and report that 75 of 92 coroners' jurisdictions in England submitted responses in 2013, a coverage rate of 81.5%.

NPSAD reported 1,344 cases under their definition in England in 2013, with psychoactive drugs implicated in 1,237 cases (90%). This total was similar to that for 2012 (1,363); however, the figure for 2013 is likely to increase due to late registrations. The report found that there had been a marked increase in the proportion of these deaths where heroin/morphine was implicated, from 34% in 2012 to 41% in 2013, which aligns with the recent increase in mentions of heroin/morphine reported via the England and Wales GMR. There was also an increase in the proportion of deaths where heroin/morphine was the sole drug implicated, from nine per cent to 11%.

NPSAD also request information on which psychoactive drugs were prescribed. They found that 32.5% of individuals who died from a methadone-related death ($n = 86$) were known to have had the drug prescribed to them. This equates to 37% of those with a known prescribing status.

Information pertaining to drug abuse/dependence history was available for 1,067 individuals, of whom 64% had a history. Those with a history of drug abuse/dependence were more likely to be male, to be younger, and/or experience accidental death, compared to those without such a history.

7.4.2 National Drug-Related Deaths Database (Scotland)

The fifth report from the National Drug-Related Deaths Database (NDRDD) in Scotland was published in April 2015, examining the personal circumstances of those who died a drug-related death in Scotland in 2013 (Barnsdale, Gordon, & McAuley, 2015). The drug-related deaths in the NDRDD report are a sub-set of the 581 drug-related deaths published by NRS in August 2014 (National Records of Scotland, 2014).¹²²

In 2013, there were 448 cases identified as eligible for inclusion in the main NDRDD cohort (a decrease from 479 in 2012). As with previous years, around three-quarters (76%) were male. The proportion of these deaths where the individual was aged 35 and over has increased from half of deaths (50%) in 2009 to two-thirds (66%) of deaths in 2013, while the mean age increased from 34.4 in 2009 to 39.1 years in 2013.

Nine out of ten individuals (88%) were known to be using drugs prior to death, and almost two-thirds (64%) had a known history of intravenous (IV) drug use. Over half (51%) had been prescribed an OST drug since 2009, including 31% prescribed an OST drug when they died (up from 21% in 2009). Over one-third (37%) had been prescribed an anti-depressant in the 30 days before death, with one-fifth (21%) recently prescribed diazepam and one-tenth (10%) recently prescribed gabapentin. Almost two-thirds (63%) had a psychiatric condition recorded, the highest reported so far.

Over half (53%) of those included in the cohort had been in contact with drug treatment services before they died. Seven in ten (71%) had been in contact with at least one service (drug treatment, hospital, police or prison) which may have identified them as being at risk of drug-related death.

In 68% of cases, more than one drug was implicated in the death. Diazepam was the drug most frequently found to be present (66% of cases, although down from 77% in 2009), but implicated in fewer than one-third of these cases (19% of all cases). The most commonly implicated drugs were heroin/morphine (44%) and methadone (42%), with opioids implicated in 76% of cases.

7.4.3 Public Health England analysis

Public Health England (PHE) produced an analysis of trends in drug-related deaths in England using the DMD in July 2015 based on extracts of data received from the ONS (Public Health England, 2015j). This followed the reported rise in deaths registered in England using the DMD by the ONS for 2013 (Office for National Statistics, 2014) and a national summit on drug-related deaths in England held in January 2015. However, it predated the latest ONS bulletin (Office for National Statistics, 2015).

For this analysis, PHE reported figures based on year of death, highlighting that registration delays meant that later years were incomplete. The PHE analysis found that a large number of drug misuse deaths registered in 2013 had occurred in the same year (892 deaths), but that there had also been an increase in deaths registered after more than a year. It should be noted that the subsequently published data on 2014 registrations in England from the ONS indicated a further rise, and the PHE report commits to updating the analysis going forward.

The analysis also found that among deaths where heroin was mentioned on the death certificate, there was a clear long-term trend towards other substances (including alcohol) being mentioned alongside heroin, and away from heroin being the only drug mentioned. A data linkage exercise between drug poisoning data and drug treatment data was included in this report, showing that three-fifths (59%) of opioid misuse deaths in 2011 had received no treatment since at least 2006 (and possibly never).

¹²² Since the latest NDRDD report was published, the NRS has published figures for 2014 (National Records of Scotland, 2015)

This proportion had remained reasonably consistent over the full period studied (2008-2012). When considered in the context of prevalence estimates and treatment numbers, the analysis suggested that treatment had a significant protective effect for opioid users, supporting the findings of the previously mentioned White et al. (2015) study. However, it also suggested that there has been little change in the extent of the protective effect in recent years.

7.4.4 Relative safety of buprenorphine and methadone

Marteau et al. (2015) published an analysis looking at population-wide overdose risk emerging from the prescription of methadone and buprenorphine in OST in England and Wales (Marteau, McDonald, & Patel, 2015). For this analysis, drug-related deaths where methadone and buprenorphine were mentioned were presented as a rate of all prescriptions issued for these drugs, between 2007 and 2012. In this period there were 2,366 deaths where methadone was mentioned and 52 where buprenorphine was mentioned, with 17.3 million methadone prescriptions and 2.6 million buprenorphine prescriptions issued. This translates to rates of 0.137 deaths per 1,000 prescriptions of methadone and 0.022 per 1,000 prescriptions of buprenorphine, or a relative risk ratio of 6.23 (with 95% CI: 4.79 to 8.10). Therefore, the authors assert that buprenorphine is six times safer than methadone in regard to overdose risk in the general population and suggest that clinicians should be aware of this increased risk, as well as recommending that tighter regulations are needed to prevent diversion.

7.4.5 Calls for legislative change around registration of deaths in England and Wales

In a correspondence to the *Lancet* in May 2015 on behalf of the Royal Statistical Society (RSS), Professor Sheila Bird reiterated a call for legislation to change the process of registration of deaths in England and Wales.¹²³ Bird cited lengthy delays in relation to registration of drug-related deaths and suicides in particular, urging the *Lancet* and the Farr Institute of Health Informatics Research to join the RSS in lobbying the government on this issue.

7.4.6 Deaths from HIV/AIDS

Based on reports received up to the end of March 2014¹²⁴, in England and Wales, there were 1,555 AIDS deaths of people whose exposure category was recorded as either “injecting drug use” or “sex between men and injecting drug use”. This accounted for 7.9% of AIDS deaths recorded up to that date ($n = 19,743$). In Northern Ireland, there were 8 AIDS deaths of people who inject drugs (PWID) which accounted for between 6% and 7% of all AIDS deaths.¹²⁵ In Scotland the percentage was much higher at 45.1% of AIDS deaths (864 deaths, $n = 1,915$) (Public Health England, unpublished data).

7.4.7 Deaths from hepatitis C

Both hospital admissions and deaths from hepatitis C virus (HCV)-related end stage liver disease and hepatocellular carcinoma are continuing to rise in the UK (Public Health England, 2015f). Hospital admissions rose from 611 in 1998 to 2,658 in 2013, while deaths rose from 98 in 1996 to 424 in 2013.

This increase is particularly notable in Scotland where liver-related deaths among people diagnosed with hepatitis C increased 3.2-fold from 43 in 1996 to 139 in 2013. However, in the last five years (2009-2013), the annual number of liver-related deaths has remained relatively stable. Linking records from Scotland's National Hepatitis C Diagnoses Database to the national register of deaths showed that 851 (52%) of the total 1,638 liver-related deaths during 1996-2013 among people diagnosed with hepatitis C had any mention of hepatitis C on their death certificate. Among the 139 liver-related deaths in 2013, only 110 (79%) had liver disease recorded as the underlying cause of death (alcoholic liver disease was the most prevalent underlying cause in 36). It is therefore likely that the total number of deaths recorded as HCV-related end stage liver disease is an underestimate of the true situation.

¹²³ See: <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2960920-5/fulltext?rss%3Dyes>

¹²⁴ Numbers for 2013 and 2014 are likely to increase as further reports are received; data presented are from reports received to the end of March 2014.

¹²⁵ The total number of AIDS deaths in the period in NI was between 120 and 124. Due to suppression of statistics under five n could not be established precisely from published data.

7.5 New developments

7.5.1 Control of tramadol under the Misuse of Drugs Act 1971

Tramadol became a schedule 3 controlled drug under the *Misuse of Drugs Act 1971* in June 2014 (UK Focal Point, 2014), following advice from the Advisory Council on the Misuse of Drugs (ACMD), which expressed particular concern about the increasing number of deaths in the UK involving tramadol (Advisory Council on the Misuse of Drugs, 2013). ONS reported 240 deaths registered in 2014 in England and Wales where tramadol was mentioned (Office for National Statistics, 2015). Although this was the highest number yet recorded, due to registration delays it is not possible as yet to assess the effect of the control of tramadol on the number of deaths related to tramadol. Scotland reported a fall in drug-related deaths where tramadol was implicated from 64 in 2013 to 38 in 2014.

7.5.2 Deaths in Northern Ireland due to 4,4'-Dimethylaminorex and subsequent response

Cosbey et al. (2014) identified a total of 18 drug abuse deaths in Northern Ireland where the synthetic stimulant 4,4'-DMAR was detected alongside other substances in toxicology samples (Cosbey et al., 2014). The ACMD identified 37 deaths in total in the UK associated with 4,4'-DMAR and recommended that this compound be controlled under the *Misuse of Drugs Act 1971* as a class A substance. 4,4'-DMAR became a class A drug in March 2015.

7.5.3 Deaths in prison

In July 2015, the PPO reported on 19 deaths which have occurred in prison between April 2012 and September 2014, where the prisoner was known or strongly suspected to have been using NPS-type drugs before their death (Prisons and Probation Ombudsman, 2015) (see section 8.7.1)

7.5.4 Preventing drug-related deaths

In April 2014, PHE published a briefing on *Preventing Drug-related Death* (Public Health England, 2014e). The briefing contains practical advice for commissioners and services on preventing drug-related deaths and additionally provides prompts to ensure best practice.

In June 2014, the Welsh Government published *Guidance for Undertaking Fatal and Non-Fatal Drug Poisoning Reviews in Wales* (Welsh Government, 2014a). The guidance outlines the framework and procedures to undertake reviews of drug poisonings in Wales in line with the key aims within their substance misuse strategy (Welsh Assembly Government, 2008a). This document provides guidance for all stakeholders within Wales who have a remit for reducing fatal and non-fatal drug poisonings, and encompasses all stages of review including instigation, collaborative working with statutory bodies in data collection, establishment and implementation of recommendations/lessons learned and dissemination of information for action.

8. Drug users in prison

8.1 Introduction

The link between substance misuse and crime is strong and represents a major challenge to the efforts to turn prisoners away from further criminal activity. Offenders do not necessarily want to stop taking drugs just because they have been imprisoned and so the demand for drugs in prisons is strong. For many prisoners they form a 'lifestyle' as well as a physical and psychological dependency. As such there is an unwelcome but deeply held desire for drugs in prisons: to maintain dependency; as recreation; to continue the 'lifestyle' or; to make money out of their supply. Drugs can have a number of different impacts in prisons. In addition to making rehabilitation more difficult, they can: present significant health risks; cause unpredictable and violent behaviour; put pressure on families and staff to supply them; and form the basis of a trade which involves debt, intimidation and violence.

From April 2011, the Department of Health (DH) assumed responsibility for funding both clinical and non-clinical drug and alcohol treatment in all prisons and the community in England. The responsibility for commissioning substance misuse services was devolved to local partnerships in line with the key *Patel Report* recommendation that integrated and needs-led treatment services are best commissioned at a local level (Department of Health, 2010). In April 2013, as part of the new health and care changes set out in the *Health and Social Care Act 2012* (Her Majesty's Government, 2012b), National Health Service (NHS) England became responsible for commissioning health services in prisons and other secure accommodation in England.

In May 2013, the Ministry of Justice (MoJ) published a new strategy, *Transforming Rehabilitation: A strategy for reform* (Ministry of Justice, 2013b), with the aim of reforming the criminal justice system (CJS) and reducing reoffending rates for prisoners. One of the proposed actions was to provide offenders with the support they need "through the prison gate", offering continuous support, including treatment for substance misuse, from custody into the community.

In Wales, health services are the responsibility of the Welsh Government, with responsibility for commissioning devolved to local Health Boards. The National Offender Management Service (NOMS) retains responsibility for non-clinical substance misuse services for sentenced offenders. In Scotland, responsibility for the provision of health care services in prisons transferred from the Scottish Prison Service (SPS) to the NHS in November 2011. A range of health and substance misuse services are now provided within Scottish prisons by the respective local Health Boards. In Northern Ireland (NI), the South Eastern Health and Social Care Trust (SEHSCT) assumed responsibility to providing healthcare in prisons in 2008.

Those in prison have access to a range of treatment services for substance misuse including clinical services such as detoxification and opioid substitution treatment (OST), structured psychosocial interventions, case management and structured counselling. Testing for HIV and hepatitis, and the vaccination against hepatitis B are also available. In Scotland, Take Home Naloxone (THN) is widely available for prisoners at risk of opioid overdose on release and is becoming increasingly available in England and Wales.

There are a range of measures to prevent drugs entering prison including clearly-defined searching procedures covering all possible routes; passive and active dogs, with passive dogs available to all prisons; CCTV surveillance of all social visit areas and low-level fixed furniture; and comprehensive measures to tackle visitors attempting to smuggle drugs, including closed visits, visit bans and police arrest.

8.2 Prison service overview

8.2.1 Custodial estate

England and Wales

There are currently 123 prisons in England and Wales; 121 of which are currently in use. The majority are run by Her Majesty's Prison Service, whilst 14 prisons are currently contracted out to private companies. Of the 121 prisons in use, 12 establishments are for female inmates, five are Young Offender Institutions (YOIs) and three are Immigration Removal Centres (IRCs) (National Offender Management Service, 2015b).

Prisoners on remand are generally kept in separate establishments to those in which prisoners are held after being handed down a custodial sentence. When sentenced, adult male prisoners are assigned to the correct security category and allocated to an appropriate prison. Categorisation is based on the level of risk a prisoner might pose to the public or national security should they escape and the likelihood of their making attempts to do so, as set out in the Prison Service Instruction (PSI) 40/2011.¹²⁶

There are four different security categories:

- Category A – Prisoners whose escape would be highly dangerous to the public, or the police, or the security of the state and for whom the aim must be to make escape impossible. Category A prisoners are subdivided further into Standard risk, High risk and Exceptional risk, based on their likelihood of escaping.
- Category B – Prisoners for whom the very highest conditions of security are not necessary but for whom escape must be made very difficult.
- Category C – Prisoners who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt.
- Category D – Prisoners who present a low risk; can be reasonably trusted in open conditions and for whom open conditions are appropriate.

Types of prison

There are multiple types of prison operating throughout England and Wales, designed to accommodate the different categories of prisoners whilst they are on remand and post-conviction (see Table 8.1).

Young offenders

Offenders under the age of 18 are held in either a Secure Children's Home (SCH), a Secure Training Centre (STC), or a Young Offender Institution (YOI). SCHs and STCs are for those aged under 18 years old only, while YOIs hold offenders up to the age of 25. Typically those aged less than 15 years old will be held in a SCH and those over 15 will be held in either a YOI or STC. For female young people only those aged 17 years or older are normally placed in a YOI. There are eight YOIs holding young males in England and Wales and three female young person units in England, which are attached to adult prisons. From April 2013 to March 2014, most young people under the age of 18 held in custody in England were in YOIs (68%), 22% were in STCs and the remaining 11% were in SCHs (Public Health England, 2015d).

Young offenders are classified as suitable for either closed or open conditions according to PSI 41/2011.¹²⁷

¹²⁶ See: <http://www.justice.gov.uk/offenders/psis/prison-service-instructions-2011>

¹²⁷ See: <http://www.justice.gov.uk/offenders/psis/prison-service-instructions-2011>

Table 8.1: Types of prison in England and Wales

TYPE OF PRISON	DESCRIPTION
Local	There are 31 local prisons, which serve the courts and receive remand and post-conviction prisoners, before their allocation to other establishments. They hold many short-term prisoners including remand prisoners, those awaiting allocation to training prisons and may hold a small number of immigration detainees.
Training	May be open or closed and offer courses and training as part of prisoner rehabilitation. A number of category 'C' training prisons have also been identified as "resettlement prisons".
Open	Accommodate category 'D' prisoners, as well as indeterminate and longer-sentenced prisoners who are coming toward the end of their sentence and who have gradually worked their way down the categories. Open prisons are part of the resettlement programme to reintegrate prisoners back into society.
Resettlement	Established under <i>Transforming Rehabilitation: A strategy for reform</i> (Ministry of Justice, 2013), resettlement prisons are expected to hold category 'C' prisoners who will engage with resettlement providers in the last three months of their sentence. Offenders released from these prisons are expected to leave with a package of support in place, delivered by one of the new Community Rehabilitation Companies (CRCs), enabling better linkage with local settlement services and improved family contact.
High Security	There are two types of high security prison: dispersal prisons and local prisons. Core locals primarily serve the courts and the majority of their population are those described in the local prisoner section (i.e. those on remand or awaiting sentence), as well as short-term sentenced category 'B' and 'C' prisoners from the local area. The dispersal prisons serve to spread the category 'A' population, ensuring that the most dangerous prisoners are not concentrated in a single establishment, thereby reducing the risks involved in holding them. There are eight high security prisons in England and Wales.
Female	Of the 12 female prisons, only two are closed training prisons; the rest have a combined local and trainer function. All female prisons have been identified as resettlement prisons.
Immigration Removal Centre	These establishments are holding centres for foreign nationals awaiting decisions on their asylum claims, or awaiting deportation following a failed application. They are operated on behalf of the Home Office by the MoJ's NOMS.

Source: (National Offender Management Service, 2015b)

Inmate profile

There are approximately 100,000 unique admissions to the prison system in England and Wales within the year. The prison population on any given day is around 85,000 (Public Health England, 2015d). Approximately 81,000 inmates are male. In March 2015 the YOI population of under 18 year olds was 1,004, consisting of 966 males and 38 females (Ministry of Justice, 2015c).

Scotland

The Scottish Prison Service (SPS) has 15 prisons, including one open estate prison, Her Majesty's Prison (HMP) Castle Huntly. Thirteen of the prisons are publicly managed and two prisons are operated by private sector companies under contract to the SPS.

The available design capacity for prisons in Scotland is for 8,082 prisoners (personal communication – Scottish Prison Service). The average daily prisoner population during 2014/15 was 7,306 male and 425 female inmates, totalling 7,731 (Scottish Prison Service, 2015).

Northern Ireland

In NI there are three publicly run prison establishments, one of which includes a young offenders' centre. There are two male prisons and one female prison.

In March 2015 the prison population consisted of 1,726 inmates: 66 adult females, 1,546 adult males and 114 young offenders (three female and 111 male) (Northern Ireland Prison Service, 2015).

8.2.2 Community

England and Wales

Under the new rehabilitation reforms, which commenced operation in early 2015, Community Rehabilitation Companies (CRCs) will be required to ensure that all sentence requirements or licence conditions/supervision requirements are delivered for the offenders they manage. This includes more punitive or restrictive elements of a Community or Suspended Sentence Order such as unpaid work or exclusion requirements, or specific licence conditions such as drug testing. CRCs will oversee the sentence of the court for each offender allocated to them to manage, and in doing so seek to rehabilitate offenders and reduce reoffending. These reforms will ensure that essentially every offender released from custody will receive statutory supervision and rehabilitation in the community.

8.3 Strategy and co-ordination

8.3.1 Prison drug strategies

England and Wales

In December 2010 the MoJ published a Green Paper, *Breaking the Cycle* (Ministry of Justice, 2010), which proposed fundamental changes to the penal system based on the four principles of: protecting the public; punishing and rehabilitating offenders; transparency and accountability; and decentralisation. A key aim was to ensure prisoners were able to break the cycle of offending and incarceration through rehabilitation.

A component of the report was to support offenders to recover fully from their addiction to drugs and/or alcohol whilst they were in prison. Proposed actions included working to reduce the availability of illicit drugs in prison, introducing pilots for Drug Recovery Wings (DRWs) in prisons, and to commence pilot payment by results schemes for providers who run the prison-based treatment services.

In the same year, *The Patel Report* (Department of Health, 2010) was published which reviewed the prison drug treatment strategy and made a number of recommendations for the future. The ultimate aims of the drug strategy for prisons are that: offenders who use drugs cease their drug use in prison; that those who do not use drugs do not start to do so in prison; and that abstinence continues after release into the community. The Prison Service Drug Strategy (Department of Health, 2010) has two aims:

- to reduce the demand for drugs in prisons; and
- to reduce the supply of them

These aims are pursued through a combination of measures focusing on treatment, enforcement, and security:

- detoxification (clinical management of withdrawal);
- provision of integrated substance misuse services and interventions;
- mandatory drug testing to deter prisoners from misusing drugs;

- information on patterns of drugs misuse, as well as identifying prisoners in need of treatment;
- communication and education to prisoners on the dangers associated with using drugs;
- voluntary or compact-based testing programmes;
- legislative and other mechanisms to enable an effective response to those who choose to abuse drugs; and
- effective security measures aimed at supply reduction, including:
 - passive search dogs, which are available in all prisons, to detect visitors carrying drugs, and active search dogs, used to search goods and vehicles;
 - strict measures to tackle visitors who smuggle or attempt to smuggle drugs. This includes, on suspicion of smuggling, ‘closed’ visits (i.e. through a glass screen) or visit bans, and arrest and prosecution where there is sufficient evidence; and
 - effective intelligence systems, targeting those trafficking drugs

In May 2013, the MoJ published a new strategy, *Transforming Rehabilitation: A strategy for reform*, (Ministry of Justice, 2013b), with the aim of reforming the CJS and reducing reoffending rates for prisoners. One of the proposed actions was to provide offenders with the support they need “through the prison gate” by offering continuous support, including treatment for substance misuse, from custody into the community. The strategy also called for new legislation which would make engagement with rehabilitation mandatory over a 12 month period for all prisoners released from short custodial sentences of up to two years. Upon release, offenders would be subject first to a standard licence period and then to an additional supervision period for the purpose of rehabilitation. Following release from prison offenders will be supervised by either a CRC, who supervise low to medium risk offenders, or through the National Probation Service, which supervises the highest risk offenders.

CRCs will be required to ensure that all sentence requirements or licence conditions/supervision requirements are delivered for the offenders they manage. This includes more punitive or restrictive elements of a Community or Suspended Sentence Order such as unpaid work or exclusion requirements, or specific licence conditions such as drug testing. CRCs will oversee the sentence of the court for each offender allocated to them to manage, and in doing so seek to rehabilitate offenders and reduce reoffending. These reforms will ensure that essentially every offender released from custody will receive statutory supervision and rehabilitation in the community.

Scotland

The role of prison-based drug treatment programmes is highlighted in the 2008 Scottish Drug Strategy, *Road to Recovery: A new approach to tackling Scotland's drug problems* (Scottish Government, 2008c), as a means of assisting recovery. In the same year, the Scottish Government commissioned a task force to investigate health inequalities and published a new strategy, *Equally Well* (Scottish Government, 2008b). One of the key recommendations was for offenders who want to tackle their drug problems to be able to get access to addiction and health services within six weeks of release from prison. Improving the health and well-being of offenders was also cited as a means to reduce inequalities associated with violence and alcohol and drug problems. In 2010 a review of the strategy was conducted and it was agreed to continue offering Throughcare Addictions Services, which offer wraparound support to offenders with addiction issues being released from prison (Scottish Government, 2010c).

The *Strategy framework for the management of substance misuse in custody* (Scottish Prison Service, 2010) reflects the aims and objectives of the Scottish Government's national Drug Strategy. Over the past decade policy on managing prisoners with problematic substance misuse has moved from a punitive response to a therapeutic approach; offering a comprehensive integrated treatment service to support

recovery and community integration and to reduce reoffending. The Strategy focuses on robust security systems to divert, disrupt, detect and deter the supply of illicit substances and to support the provision of treatment services to encourage prisoners to reject the illicit drug culture.

In 2011 the responsibility and accountability for the provision of health services in prison, including substance misuse and mental health services, transferred to NHS Health Boards who provide a range of health and substance misuse services, broadly comparable to that available in the community. The emphasis is on recovery focused treatment options, including naloxone provision and improved Throughcare Services. An independent expert review of OST in Scotland, published in 2013, acknowledged the role that prison healthcare has to play in delivering OST to assist recovery (Drug Strategy Delivery Commission, 2013).

Northern Ireland

There is a real and concerted effort by the Northern Ireland Prison Service (NIPS) to address substance misuse based around a three strand approach: to restrict supply, to reduce demand and to assist recovery.

In March 2012 NIPS and the SEHSCT, who assumed responsibility for providing healthcare, including addiction services, in prisons in 2008, jointly published a ***Strategic Framework for the Reduction and Management of Substance Misuse in Custody***. The framework reinforced the two organisations' commitment to working in partnership to address misuse.

The purpose of the framework is to provide strategic direction and guidance in the management of prisoners with substance problems. The NIPS and the SEHSCT will take all reasonable measures to reduce the availability of illicit substances to prisoners; and to provide recovery-aiding services broadly equivalent to those available in the community, whilst recognising that prisoners require different routes to recovery.

The strategic aims are to:

- reduce the availability and supply of illicit substances;
- reduce the levels of substance misuse through recovery-based treatment programmes;
- ensure treatment programmes are integrated with, not separate from, a wide range of related prison-based services; and
- develop substance misuse services to reflect the diverse needs of the prisoner population

In 2013 the Prison Service increased its focus on intelligence-led searching and there have been increased drugs finds in all three prisons. Both NIPS and SEHSCT are currently in the process of revising the substance misuse policy and strategy. The new SEHSCT Strategic Framework (July 2015) is currently in draft form. It aims to provide a template to ensure that substance misuse issues are recognised and that the challenges arising from a number of inspection reports, including joint CJINI/Her Majesty's Chief Inspector (HMCI) and Regulation and Quality Improvement Authority (RQIA) inspections, and more recently, the publication of the ***Safety of Prisoners held by the Northern Ireland Prison Service*** (Criminal Justice Inspection Northern Ireland, 2014) report, are addressed. This can only be achieved through a multi-disciplinary, collaborative, partnership approach, not only involving staff from SEHSCT, Alcohol and Drugs: Empowering People through Therapy (AD:EPT) and NIPS, but also a significant range of other providers, including support from community and voluntary sectors organisations, for example, Alcoholics Anonymous and Narcotics Anonymous (NA).

A draft strategy has been developed outlining how NIPS and the SEHSCT will work together to:

- understand the scale of the problem;
- implement supply reduction methodologies which will prioritise disrupting supply routes before substances reach the end user;
- provide clear engagement and treatment pathways for substance misusers; and
- ensure through care and continuity of treatment and support services on release from prison

In addressing concerns raised in a number of scrutiny reports, and incorporating the guidance of the Drug Strategy (Department of Health Social Services and Public Safety Northern Ireland, 2011b), the SEHSCT is committed to reducing the level of alcohol- and drug-related harm in NI prisons. To achieve this SEHSCT is committed to key underpinning principles including: being person centred, non-judgemental and empowering; harm reduction; best practice; holistic care; equity and inclusion; shared responsibility; consultation, engagement and transparency; and an integrated approach.

8.3.2 Co-ordination of drug-related prison health responses

England

In England, the DH is responsible for determining the policy on substance misuse treatment and suitable approaches, including the balance between clinical treatment and psychosocial interventions. Substance misuse treatment services in custody are commissioned and funded by NHS England.

NOMS and Public Health England (PHE) have a co-commissioning responsibility with NHS England to enable and support the efficient delivery of provision. The *National Partnership Agreement for the Co-Commissioning and Delivery of Healthcare in Prisons in England* (National Health Service England et al., 2015), a tripartite agreement between NHS England, PHE and NOMS, sets out respective roles, shared principles and development priorities as well as objectives to work together and address any issues arising from changes to the delivery environment. The agreement is overseen by the Prison Healthcare Board (England). In October 2014, the 35 former Probation Trusts were dissolved and their responsibilities were transferred to either the newly established National Probation Service within NOMS, or the CRCs.

Wales

In Wales, health and delivery of its services within the public sector prisons are the responsibility of the Welsh Government, with responsibility for service provision devolved to local Health Boards. NOMS retains responsibility for its non-clinical substance misuse services for sentenced offenders.

Resettlement in England and Wales

Key to successful drug treatment outcomes is continuity of treatment following release. The MoJ has been working closely with partners in health to help extend the focus of substance misuse treatment and recovery services in prison to plan and operate through the gate into the community. A network of 89 resettlement prisons has been established under *Transforming Rehabilitation: A strategy for reform* (Ministry of Justice, 2013b), in order to provide support for prisoners within the last three months of their sentence who are returning to their home area. In addition, a comprehensive “end-to-end” approach to tackling addiction from custody to the community is being developed and tested in a number of resettlement prisons. DH funding has enabled NOMS, NHS England and PHE to test new pathway arrangements, develop products which can be used across the country, and capture learning by working closely with 10 resettlement prisons as early adopters in the north-west. The emphasis has been on joining up services in prison and on release.

Scotland

In Scotland, responsibility for the provision of health care services in prisons transferred from the SPS to the NHS in November 2011. A range of health and substance misuse services are now provided within Scottish prisons by the respective local Health Boards.

Northern Ireland

The provision of substance misuse services within NI prisons has undergone significant change in recent years. The transfer of responsibility for prison healthcare services to the SEHSCT, and recommendations from a number of independent reviews, surveys and inspections have influenced and reflected on a period of continued transition and change.

8.4 Drug use and problem drug use in prisons

8.4.1 Drug use prior to imprisonment

Surveying Prisoner Crime Reduction study in England and Wales

Light, Grant and Hopkins used data from the first wave of the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study to explore substance use and gender differences (Light, Grant, & Hopkins, 2013). Eighty-one per cent of the cohort reported having taken illicit drugs at some point in their lives, with no difference between genders in this measure or for drug use in the last four weeks before custody (64% overall). Females were more likely than males to report ever using heroin (55% compared to 39%) and to report the use of Class A drugs in the four weeks prior to custody (58% compared to 43%). Nineteen per cent of those who reported ever using heroin said that they had first done so in prison, with male heroin users (38%) more likely to report doing so than female heroin users (10%). Just under one-third of prisoners said their offending was always connected with their drug use, with females more likely to report this than males (50% and 28% respectively). Females were also more likely to report that they needed help with a drug problem on entry to prison (49% compared to 29% of males). A similar divergence was also found in the 2014/15 survey by Her Majesty's Inspectorate of Prisons (HMIP) in which 28% of male and 41% of female new arrivals at prison stated they had substance misuse needs (Her Majesty's Inspectorate of Prisons, 2015).

Young adults (18-20 year olds) were less likely to report substance misuse needs compared to older prisoners (15% and 33% respectively) (Ministry of Justice, 2015b). The drugs used across age groups differed also, with young adults significantly more likely to report having used cannabis, cocaine, LSD or ecstasy in the year before custody, whilst older adult prisoners were more likely to report having used crack cocaine, heroin, illicit tranquilisers and illicit methadone.

Addiction prevalence testing in Scotland

Data shows that of the 1,170 addiction prevalence tests (APTs) carried out on reception to prisons in Scotland during 2014/15, 70% were positive for illicit drugs, down from 77% in the previous year. Benzodiazepines and cannabis remained the most frequently detected drugs, being detected in 46% and 42% of tests respectively. This was a decrease in positive tests from the previous year for both drugs, when they were each detected in 50% of tests (see Table 8.2). The proportion of tests positive for opioids decreased significantly from 33% to 26%, the lowest figure recorded since APT began in 2007. Following an increase in the percentage of positive tests for cocaine last year, there was a small decrease this year, with the level remaining higher than that seen in 2012/13.

Table 8.2: Percentage of positive tests on reception to Scottish prisons, 2008/09 to 2014/15

	2008-09	2009-10	2010-11	2011-12	2012-13*	2013-14†	2014-15‡
Amphetamines	2	1	2	1	3	3	2
Barbiturates	-	0	1	1	0	1	0
Benzodiazepines	49	38	53	48	47	50	46
Buprenorphine	3	0	2	3	9	9	7
Cannabis	42	28	40	35	45	50	42
Cocaine	6	6	8	9	9	13	11
Methadone	4	6	11	7	11	9	9
Opioids	36	36	36	34	31	33	26
All illicit drugs	71	56	73	70	72	77	70

*From <http://www.scotpho.org.uk/downloads/drugs/SPS-Addiction-Prevalence-Testing-Stats-Final-2012-13-v2.pdf>

†From <http://www.scotpho.org.uk/downloads/drugs/SPS-Addiction-Prevalence-Testing-Stats-Final-2013-14.pdf>

‡From <http://www.scotpho.org.uk/downloads/drugs/SPS-Addiction-Prevalence-Testing-Stats-Final-2014-15.pdf>

Source: (Scottish Government, 2010a, 2010b, 2012)

The 2013 *Scottish Prisoner Survey* (Scottish Prison Service, 2014) results show that two in five respondents reported being under the influence of drugs at the time of their offence (39%), with around one-sixth reporting that they committed their offence to get money for drugs (16%).

8.4.2 Drug use inside prison

England and Wales

Mandatory drug testing

Mandatory drug testing (MDT) was introduced as part of the *Criminal Justice and Public Order Act* (Her Majesty's Government, 1994) and involves collecting urine samples from prisoners, which are then analysed for evidence of illicit drug use.¹²⁸ It is used to estimate the level of drug use within prisons as well as to identify individual drug users, who can then be offered support and/or sanctioned. There are five ways in which drug testing can be undertaken under Prison Service Order (PSO) 3601:¹²⁹

- random testing — prisoners selected on a random basis;
- reasonable suspicion — prisoners selected where there is reason to believe they have misused drugs;
- risk assessment — prisoners selected where they are being considered for a privilege or position of trust (such as Release on Temporary Licence or a job);
- frequent test programme — prisoners selected because of their previous history of drug misuse; and
- reception testing — prisoners selected on a routine or occasional basis

¹²⁸ Each sample is analysed automatically for eight groups of drug: cannabis, opioids, cocaine, benzodiazepines, methadone, amphetamines, buprenorphine and barbiturates. NPS are not currently detectable.

¹²⁹ See: <http://www.justice.gov.uk/offenders/psos>

The target for Random Mandatory Drug Testing (RMDT), previously set at five per cent of the population in prisons with an average population in the previous 12 months of 400 or more inmates and 10% of the population for those with less than 400, was removed in 2011/12 although the information is still collected for management purposes. In England and Wales during 2014/15, the rate of drug misuse as reflected by those testing positive in MDT was 6.9% (National Offender Management Service, 2015a). This was a decrease from the rate for the previous year of 7.4% but similar to the rate observed in 2012/13 (seven per cent) (National Offender Management Service, 2014).

Whilst positive RMDT rates of just seven per cent were recorded in 2014, reasonable suspicion testing yielded a substantially higher rate of 30% (The Centre of Social Justice, 2015). However, levels of suspicion testing have dropped by 21% in the last two years. In 2014/15 59% of establishments did not consistently complete all requested suspicion MDTs in line with Prison Service requirements (Her Majesty's Inspectorate of Prisons, 2015).

Her Majesty's Chief Inspectorate of Prisons Report

The HMIP Report 2014/15 included survey results showing that 32% of adult male respondents stated that illicit drugs were "easy" or "very easy" to obtain in their prison (Her Majesty's Inspectorate of Prisons, 2015). This rate varied depending on the type of establishment prisoners were held in, rising to 44% of respondents in Category C training prisons and falling to 18% of those held in high security prisons. Furthermore, some prisoners stated they had actually developed problems with illicit drugs (seven per cent) or diverted medications (seven per cent) since entering prison (Her Majesty's Inspectorate of Prisons, 2014). Over one-third (37%) of adult male prisons stated that the use of new psychoactive substances (NPS), specifically 'Spice' and 'Black Mamba', are of increasing concern (Her Majesty's Inspectorate of Prisons, 2014).

Surveying Prisoner Crime Reduction study

Data from the second and third waves of the SPCR examined prisoners' experience of prison and their outcomes on release (Ministry of Justice, 2014b). The findings suggested that whilst 40% of prisoners reported that they needed help for substance misuse, only 27% received support. A survey of longer-sentenced prisoners¹³⁰ found that 30% reported that they had used illicit drugs at some point during their sentence. The most commonly reported used drug was cannabis (22%), followed by heroin (14%).

Seizures of drugs inside prisons

There were almost 4,500 seizures of illicit drugs in prisons in England and Wales in 2013/14, an increase of over 200 on the preceding year (DrugScope, 2015).

In a press release from the MoJ,¹³¹ it was stated that there were 430 seizures of Spice¹³² in the first seven months of 2014 in prisons in England and Wales. This represented 132 more seizures of the substance than in the whole of 2013.

In an effort to find out which NPS were being used in prisons, in 2014/15 893 samples were collected from prisons in the south-west and north-west of England and analysed by the Forensic Early Warning System (FEWS). The results showed that the vast majority (738) contained non-controlled NPS, most commonly synthetic cannabinoids (Home Office, 2015a).

¹³⁰ Those sentenced to between 18 months and four years. Base size 2,164.

¹³¹ See: <https://www.gov.uk/government/news/new-crackdown-on-dangerous-legal-highs-in-prison>

¹³² This figure represents the number of seizures described exactly as "Spice" on the prison administrative data system. It is possible this figure will include seizures of other cannabinoids.

Scotland

Data shows that of the 616 APT tests carried out at prisoner liberation in 2014/15,¹³³ 29% were positive for illicit drugs. This was an increase from the previous year which had 25% positive returns. The drugs most commonly detected when leaving prison were buprenorphine (13%), cannabis (eight per cent) benzodiazepines (seven per cent) and opioids (six per cent).

The 2013 *Scottish Prisoner Survey* (Scottish Prison Service, 2014) results show that two in five prisoners (38%) said that they had used illicit drugs in prison at some point. Of these, 82% said that their drug use had changed during their current period in prison. Almost two-thirds (63%) said that their drug use had decreased, whilst 14% said it had increased. Eight per cent of prisoners said they had used NPS in prison, with synthetic cannabinoids being the most commonly used (54%). Almost half of respondents reported that they had been assessed for drug use upon admission to prison (46%).

The SPS 2014/15 annual report (Scottish Prison Service, 2015) shows that 901 male and 102 female inmates were disciplined for "administering, or allowing to be administered, a controlled drug to oneself". This was an increase from 2013/14 when the figures were 790 and 79 respectively.

Wales

In Wales, the Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS) project has been working in conjunction with the Welsh prisons to analyse and profile substance finds that do not have any evidential or forensic value. The main aim of this collaboration is to identify potential physical and mental health harm and trends in substances available within the Welsh prison estates. In addition, this work supports prison health care by allowing substance misuse teams and wider prison staff to address the challenges posed by those using drugs and by enabling the delivery of pragmatic and tailored harm reduction messages. These messages can then be passed in to community-based criminal justice services, helping to facilitate continuity of care and consistency of service provision. From November 2013 to September 2015 WEDINOS received 198 samples from three Welsh prisons. The most commonly identified substances were Synthetic Cannabinoid Receptor Agonists (SCRAs), more commonly known within the prison estate as 'Spice' and 'Mamba'. Other drugs profiled include a range of image and performance enhancing drugs and a small number of stimulants and benzodiazepines.

Northern Ireland

In 2012/13 703 individuals presented to drug treatment in prisons in NI. Primary cannabis use was the most common reason for presentation (30.4%), followed by benzodiazepines (18.6%), heroin (11.5%) and cocaine (11.4%). The percentage of treatment presentations for primary cannabis and primary benzodiazepine users were less than those presenting to outpatient treatment in the community (40.1% and 26.5% respectively). Conversely primary cocaine and primary heroin users accounted for almost double the proportion of prison presentations than those in the community (5.4% and 5.2% respectively) (ST34, 2014).

Additionally, *The Prisoner Quality of Life Survey 2012* found that 50% of respondents reported having emotional well-being/mental health issues; 44% reported having an alcohol problem when they came into prison; 39% had a problem with drugs when they came into prison, and 31% had a problem with prescription drugs (Roisin Broderick Scottish Prison Service Research Branch, 2013). Results from the survey also revealed that the most commonly drugs used were: cannabis (22%); benzodiazepines (16%); co-codamol (12%); tramadol (12%); ecstasy (11%); and Subutex® (buprenorphine; 11%).

The capturing of statistical information about substance misuse in NI prisons is currently being reviewed as part of the Prison Reform Workstream.

¹³³ See: <http://www.scotpho.org.uk/downloads/drugs/SPS-Addiction-Prevalence-Testing-Stats-Final-2014-15.pdf>

8.5 Drug-related health in prisons

8.5.1 Drug-related health problems

Blood-borne viruses

England

In April 2014 a new opt-out testing programme for blood-borne viruses (BBVs) was introduced in 11 prisons across England. In the first six months there was a near doubling of BBV testing from 11% to 22% of new receptions being screened in 8/11 prisons (Public Health England, 2015a). The proportion of those testing positive remained stable with 0.3% testing positive for HIV, 0.2% positive for hepatitis B and nine per cent testing positive for hepatitis C. It is hoped that opt-out BBV testing will be fully implemented across all prisons in England by 2016/17.

Wales

BBV testing programmes and access to treatment are available in each prison in Wales. In 2014, 14% of prison receptions to Welsh prisons were tested for BBVs. This was a small increase from 13% of prison receptions undergoing testing in 2013. Data demonstrates that both venepuncture and dried blood spot methods are being used for testing. Improvements to data quality related to diagnosis and referral to specialist treatment centres are being made over 2015.

Scotland

In 2009 the SPS commissioned a study into the prevalence and incidence of hepatitis C amongst prisoners (Scottish Prison Service, 2012). The hepatitis C virus (HCV) antibody prevalence among all prisoners who participated in the study (5,076 prisoners) was 19%, ranging from one per cent to 34% across prisons. However, amongst injecting drug users (IDU) the prevalence rose to 53.1%, and amongst non-IDU it fell to 2.9%.

HCV antibody prevalence was found to be higher among female prisoners who inject than male prisoners who inject, 65% and 52% respectively. HCV prevalence varies by age-group also: for those reporting injecting there was an increase from 14% HCV positive in those under 20 years old to 68% in those aged over 40 years old.

Whilst the male population showed similar rates of HCV both in prison and in the community (52% and 54% respectively), women had significantly higher prevalence in prison than in the community (65% and 54% respectively).

From the study the estimated hepatitis C incidence rate was less than one per cent (or one per 100 person years) among all prisoners, less than three per cent among prisoners with an injecting history and five to seven per cent among prisoners who had ever injected in prison (Scottish Prison Service, 2012).

Mental Health

The Rehabilitation for Addicted Prisoners Trust (RAPt), a prison treatment provider in England, conducts mental health screenings for all prisoners participating in their treatment programmes. They estimate that those accessing their treatment services have an average of 3.4 mental health problems.¹³⁴ The most common disorders were trauma symptoms shown by 71% of participants, and depressive symptoms and eating disorders, both 67% (The Rehabilitation for Addicted Prisoners Trust 2015).

Anecdotal evidence suggests that the growing levels of NPS use in prisons is linked to a number of negative outcomes including an increase in disturbed and disruptive behaviour by prisoners, increasing levels of debt and heightened levels of intimidation and violence towards both staff and prisoners

¹³⁴ Based on a sample of 6590 inmates (6198 male and 392 female), who accessed treatment between 2006 and 2014.

(see section 8.7.1) (National Offender Management Service, 2015a). The Prisons and Probation Ombudsman (PPO) reported on 19 deaths which occurred between April 2012 and September 2014 where the deceased was known, or highly suspected of, using NPS prior to death (Prisons and Probation Ombudsman, 2015).

8.5.2 Drug-related health responses

England and Wales

Drug treatment in prisons is based on an assessment of local need and designed to meet the requirements of low, moderate and severe drug misusers within the prison population — irrespective of age, gender or ethnicity — including the many that spend a comparatively short time in prison. Local commissioners have the discretion to commission services that accord with national clinical guidelines and that they judge are best oriented towards recovery (and consequential reductions in re-offending). However, in general, available interventions are:

- clinical services including clinical responses to immediate needs — such as detoxification or maintenance prescribing of methadone or buprenorphine;
- a range of accredited and non-accredited rehabilitative programmes, structured psychosocial interventions and other evidence based approaches in prisons that are designed to address prisoners' substance use, offending behaviour and contribute to their well-being. Offenders are often encouraged to learn and practise life skills that will help them on their recovery journey. These life skills, such as communication, healthy living and employment skills, will be vital for offenders sustaining a life free from substance use and crime. The variety of interventions allows the provision to meet the wide ranging needs of offenders and provide a more person-centred approach; and
- case management/continuity, structured counselling — including motivational therapy, coping/social skills training, behavioural self-control training, mutual aid (i.e. self-help) such as NA, life skills and family work

Drug treatment services in prison are commissioned on the basis of equivalence with community based treatment and underpinned by evidence based clinical guidance.

Treatment figures

Based on drug treatment data collected by the National Drug Treatment Monitoring System (NDTMS), in 2013/14 there were a total of 43,372 OST interventions across prisons in England and Wales.¹³⁵ Of these, 68.5% of interventions were provided on an opioid maintenance basis and the remaining 31.5% were supplied for opioid reduction.

Unfortunately our ability to provide the same data for 2014/15 has been compromised by the NDTMS shutdown between October 2014 and March 2015.

Harm reduction

At present needle and syringe programmes (NSP) are not available within UK prisons. However, in March 2014 the Chief Medical Officer recommended that the viability and cost-effectiveness of running such programmes be explored (Department of Health, 2014). A recent audit of hepatitis C services in a representative sample of English prisons suggested that disinfection tablets for sterilising injecting equipment were available in 81% of English prisons (Public Health England, 2015f). These tablets were accessed in a variety of ways: via dispensers (53%); distributed directly via prison officers (41%); and via healthcare staff (12%) (see section 6.6.1).

¹³⁵ See: <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2014-12-17/219264/>

Drug Recovery Wings

DRWs were piloted in five adult prisons from 2011, and a further six prisons in 2012, which also included women and young offenders. The piloting activity completed in 2014. A DH-funded independent evaluation of the DRW pilots is now underway and is due for completion in April 2016. It is for local health commissioners to decide if they wish to commission DRWs when considering how best to meet the needs of their population. A number of establishments in partnership with drug treatment providers have established their own local recovery wing or therapeutic community models outside of the original pilot areas.

Scotland

In Scotland the Better Health, *Better Lives for Prisoners Framework* (Brutus et al., 2012) was published in 2012 and aims to achieve better health outcomes for prisoners through delivery of policy, practice and environments that support health and well-being. The framework recommends work across a range of topics, delivered by a number of disciplines and involving prisoners in various capacities, including planning, feedback and peer support.

The framework proposes a vision of a healthy prison and offers a practical guide to achieve improved health outcomes and a reduction in health inequalities while also recognising and linking to offender outcomes relevant to health. The framework provides recommendations consistent with a “whole prison” approach to health improvement and is built around health promotion pillars which include tobacco, alcohol, and illicit drugs. Since its publication Scottish prisons have actively engaged in the framework on a number of initiatives including the introduction of peer mentors, workforce development and family engagement to support health and well-being. Improving health and well-being is now recognised as an integral part of purposeful activity within prisons, and work is ongoing to ensure a co-ordinated and sustainable approach.

The framework is currently being developed for offenders in the wider community; this is expected to be published by the end of 2015.

Throughcare Addiction Service in Scotland

Data from Scotland show that around 1,320 individuals received assistance from the Throughcare Addiction Service¹³⁶ on release from prison in 2012/13, a similar level to previous years and representing 50% of all voluntary assistance cases (Scottish Government, 2014a). In Scotland, the Reducing Reoffending Change Fund¹³⁷ has developed mentoring services for offenders to support them on their desistance journey. The mentors begin building a relationship with their mentee up to six months before their release; meet them at the prison gate on release; and work with them to support their reintegration back in to the community. The mentors can, therefore, support their mentee to keep appointments and attend for treatment as part of a holistic plan for release and reintegration (personal communication – Scottish Government).

The SPS provides a voluntary Throughcare Service for short term offenders with no statutory conditions placed on them. It aims to ensure that the transition from custody to the community is effectively managed in an approach that seeks to minimise the risk to the public, and to support a safe transition for service users back into the community. It does so by working collaboratively with the service users, families, colleagues and partner agencies to develop an asset-based individualised plan — “one person, one plan”. Throughcare Support Officers support offenders on their journey into desistance by working with them to prepare for and successfully make the transition from custody into the community, acting as an advocate on their behalf with partner agencies and encouraging their motivation to change through sustained engagement with key services.

¹³⁶ The Throughcare Addiction Service commenced on 1 August 2005 and forms part of the voluntary aftercare service. It is delivered by a local authority criminal justice social worker who will work with the offender in the 6 week period prior to release from custody through the 6 week period post-release offering an intensive motivational service to help the offender address their addiction and link them to appropriate services.

¹³⁷ See: <http://www.gov.scot/Topics/Justice/policies/reducing-reoffending/change-fund>

Opioid Substitution Treatment

Since October 2008, the SEHSCT has been responsible for the provision of addiction services to NIPS. Services across Maghaberry, Magilligan and Hydebank Wood prisons comprise a Clinical Addiction Team (for clinical treatments) and AD:EPT for all psychosocial interventions.

The Clinical Addiction Team provides OST within the prison setting. The staff adhere to the *Northern Ireland Opioid Substitution Services Interface Protocol between Prisons and Health and Social Care Trust Community Addiction Services (April 2015)*. The purpose of this protocol is to ensure the seamless transition of patients between community OST services and prison, and the converse. This protocol is used to manage the community-prison interface in addition to the principles outlined in the *Northern Ireland Primary and Secondary Care Opioid Substitute Treatment Guidelines*.¹³⁸

The protocol provides best practice guidance but recognises providing treatment when transferring from prison to community (or vice versa) presents challenges, particularly when unplanned or unexpected transitions take place. Clinical decisions should be made in the patient's best interests and should be balanced against risk to the patient; in some cases this may require an interruption in treatment until such times it can safely continue in the patient's new location.

Psycho-social Support/Counselling/Harm reduction

AD:EPT Drug and Alcohol service is delivered by Start360 across the three sites of the NIPS in partnership with the SEHSCT. AD:EPT is a comprehensive drug and alcohol service providing a range of services to people in custody who have problems associated with the misuse of substances.

Interventions provided by AD:EPT include:

- induction Programme;
- Addiction Severity Index (ASI) comprehensive assessment;
- 1-2-1 Casework;
- 1-2-1 Counselling;
- relapse Prevention Sessions;
- pre-Release work;
- harm Reduction;
- failed Drug Test (FDT);
- Building Skills for Recovery (BSR) behaviour change group programme;
- acupuncture; and
- naloxone training

AD:EPT works as part of a multi-disciplinary team in the prisons and in particular with the Clinical Addiction Team with the aim of delivering and promoting recovery by those who are presenting with problems associated with the misuse of substances.

¹³⁸ See: <http://www.publichealth.hscni.net/publications/northern-ireland-primary-and-secondary-care-opioid-substitute-treatment-guidelines-2013>

Drug Recovery Unit Pilot

The Drug Recovery Unit (DRU) was commissioned in July 2014 by the NIPS to assess how a therapeutic substance misuse intensive programme might work within the prison environment. The DRU is an innovative approach to treatment for prisoners who misuse drugs or alcohol and is focused on harm reduction, freedom from drugs of dependence, and provision of services and advice in a central location. This is provided through an intensive, full-time, structured programme delivered in an environment which exclusively houses prisoners committed to drug recovery.

The pilot was provided within the 15 bed Glen House Unit in Maghaberry, which is fully self-contained and isolated from the rest of the prison population. The programme was jointly facilitated by NIPS staff and drug and alcohol professionals from Start360, a voluntary sector provider. The DRU delivered an intensive programme seven days per week over a 12 week period and was built around the principles of the NOMS's BSR programme which recently replaced *Prisoners Addressing Substance Related Offending* (PASRO) as best practice for addressing substance misuse.

The DRU commenced on 28 July 2014 and completed on 17 October 2014. All the participants went through an intensive assessment process, to identify need, dependency and motivation. This process highlighted that participants came from all areas of the prison, had varying degrees of dependency, and a protracted history of drug-related adjudications and Supporting Prisoner At Risk (SPAR) incidents relating to substance misuse. Of the 12 participants who commenced the programme, 11 participants completed (one participant left early in Week 10 after completion of the BSR programme).

The findings showed:

- 11 of the 12 participants secured employment or education upon exit;
- all participants passed drug tests throughout the duration of the DRU;
- the GP reported a reduction in requests for medication;
- requested GP sessions reduced from 12 in the first few weeks to 2/3 in the last weeks;
- all participants successfully completed the NOMS accredited BSR programme;
- significant improvement in health and well-being;
- no drug-related SPARs;
- no drug-related adjudications;
- no failed drug tests; and
- a significant reduction in illicit drug use

Naloxone

Naloxone is a drug used to counter the effects of opioid overdose, such as heroin or morphine, specifically the life-threatening depression of the central nervous system, respiratory system and hypotension secondary to opioid overdose. Following release from prison, opioid users are at increased risk of opioid poisoning and there are initiatives in the UK to distribute THN kits to prisoners upon release to reduce the risk of fatal overdose. In October 2015 new legislation came into effect in the UK, making naloxone exempt from prescription only medicine (POM) requirements when it is supplied by a drug service commissioned by a local authority or the NHS. Although naloxone remains a POM, this will make naloxone easier to access by individuals who have previously used opioids (see section 2.2.1).

Scotland

There is a National Naloxone Advisory Group for Scotland which has been engaged with the Scottish Government to manage central funding allowing for continued service provision. The SPS and NHS Health Boards work in partnership to enable prisoners to undertake naloxone training whilst in custody and receive a naloxone kit on release.

There were 872 THN kits issued by prisons in Scotland in 2014/15 to persons at risk of opioid overdose (Information Services Division, 2015b). A further six kits were issued to either a service worker or a friend/family member of the person at risk. The total number of kits issued in Scottish prisons ($n = 878$) decreased by 18% in comparison to the number of kits issued in 2013/14 ($n = 1,070$), although the number remained higher than those distributed in 2012/13 ($n = 747$).

There has been a steady decline in the percentage of all opioid-related deaths occurring within four weeks of prison release from the 2006-2010 baseline indicator of 9.8% to 3.1% in 2014. Performance against the baseline indicator will continue to be monitored to ensure that the percentage in the post-naloxone period is estimated with sufficient precision.

The SPS is currently conducting a pilot by delivering training in naloxone administration to operational prison staff to provide them with the competence and confidence to administer intra-muscular naloxone to prisoners in emergency 'first on the scene' situations. Lessons learned from the 'test site' will be used to inform future roll out of the training across the prison estate.

Wales

Data from the Harm Reduction Database in Wales indicates that 20.5% ($n = 116$) of male unique individuals issued with THN between 1 April 2013 and 31 March 2014 were issued with THN upon release from prison. When compared to national Area Planning Board (APB) provision, prisons are amongst the highest distributors of THN within Wales (personal communication — Public Health Wales).

England

The availability of naloxone to prisoners in England has so far been limited. Naloxone has been made available to a limited extent in some prisons, and there are proposals to pilot its use as part of the end-to-end approach to tackling addiction from custody into the community currently being tested in the north-west area (personal communication – Public Health England). A randomised trial of THN led by Kings College London (N-Alive) was initiated in early 2012 (UK Focal Point, 2012) but has now been discontinued. Naloxone distribution remains sporadic across England and its distribution is not required under treatment guidelines. However, new legislation in October 2015 will make naloxone more widely available (see section 2.2.1).

Northern Ireland

The *New Strategic Direction (NSD) for Alcohol and Drugs Phase 2 2011-16* (Department of Health Social Services and Public Safety Northern Ireland, 2011b) required the Public Health Agency (PHA) to pilot a scheme for Distributed Naloxone and for this to be reviewed. NSD Phase 2 aims to reduce the number of drug-related fatalities including those within NI prison health care. The pilot of a THN initiative is being undertaken by a partnership between the PHA and the Health and Social Care Trusts in Northern Ireland. Community Addiction Teams and the NIPS began to give out THN kits in July 2012.

The PHA service review, *Take Home Naloxone programme in NI-Consultation with service users and service providers (March 2015, Dr Gillian W. Shorter & Mr Tim Bingham)* highlighted some of the on-going challenges which include consideration of how to increase the training and take-up for those leaving prison, and reducing the time between departure and receiving their naloxone.

The THN training in NI prisons is jointly provided by AD:EPT and the SEHSCT Clinical Addiction Team. Initially it was offered to those on substitution programmes but has since been expanded to anyone at risk. The training is usually conducted in groups of 8-10 participants; however, if possible, one to one training is available if there are barriers related to group participation.

To date the statistical data collected regarding the distribution of naloxone is limited. However, it is estimated that approximately 150 THN kits have been distributed to patients being discharged from prison health care.

8.6 Quality assurance of drug-related health prison responses

8.6.1 England

There are a number of indicators in the Public Health Outcomes Framework (PHOF) (see section 5.2.1) related to people in contact with the CJS, one of which is the proportion of people assessed for substance dependence issues when entering prison who then require structured treatment and who had not previously received community treatment. The measure is designed to give local authorities an indication of the scale of treatment need unmet in the community. In 2012/13 the average proportion across England was 46.9% (Public Health England, 2015h).

Up until March 2014 a broad set of indicators, known as the Prison Health Performance and Quality Indicators (PHPQIs), were used to monitor the quality of healthcare in prisons, as well as the performance of other contributing health and prison services. However, the PHPQIs were not outcome-focused and were qualitative measures that largely relied on self-assessment by local healthcare teams. Given this and the recent changes in the commissioning of healthcare services in places of detention, it was widely agreed that the PHPQIs needed reviewing and updating. To replace the PHPQIs a new set of Health and Justice Indicators of Performance (HJIPs) have been developed by NHS England, PHE and the NOMS (National Health Service England, 2014).

The new indicators are largely quantitative measures and include specific measures for drugs and alcohol. NHS England Area Teams will work with their commissioned providers to collect the HJIPs with the aim of:

- supporting effective commissioning of healthcare services in places of detention;
- enabling national and local monitoring of the quality and performance of healthcare in the secure estate;
- providing a tool for providers to review their performance and identify areas that need improvement;
- providing data for local health needs assessments (HNAs);
- providing assurance to commissioners and partners, including NOMS, that healthcare delivery in prisons is fit for purpose; and
- providing information for the Care Quality Commission (CQC) and the HMIP to support their inspection work

The framework has been agreed and is now up and running. Collecting complete and accurate data for 2014/15 has been challenging but an annual report will be published in late 2015. Data quality and completeness are expected to improve in 2015/16.

8.6.2 Wales

Across the public sector prison estate in Wales, standards of treatment provision will be matched against those set out above. In addition, the practice standards issued by the Royal College of Psychiatrists in relation to Mental Health services for prisoners will also be adopted.

8.7 New developments

8.7.1 New psychoactive substances

The presence of NPS within prison establishments is a significant and growing problem. Ten out of 16 prisons who responded to the State of the Sector survey (DrugScope, 2015) reported an increase or significant increase in the use of NPS. Further, 13 prisons reported an increase or significant increase in the number of prisoners accessing treatment for help with the use of synthetic cannabinoids. In 2014/15 the contents of 893 samples of substances thought to be NPS were collected from prisons and analysed by the FEWS. Of these samples 738 contained non-controlled NPS, the most commonly identified substances being 5F-AKB-48 and 5F-PB-22, which are both synthetic cannabinoids (Home Office, 2015a).

The use of NPS has been linked to mental health problems and disturbed behaviour by prisoners, including violence. It is having an increasingly destructive impact on security and order in prisons, and the welfare of individual prisoners. Control and order is a fundamental foundation of prison life. Without it, staff, prisoner and visitor safety cannot be guaranteed and the rehabilitation of prisoners cannot take place.

There is a wide-ranging programme of work being undertaken by NOMS to counteract NPS. This includes joint work with the Home Office on the re-classification of drugs to enable the control of most NPS substances and to make most NPS illegal to supply (see the Psychoactive Substances Bill, section 2.2.3). This will allow prisons to press for the prosecution of those smuggling NPS into prisons or throwing them over walls (see *Serious Crime Act 2015* below). Additionally, work is underway to develop new drug tests to detect NPS substances through the MDT programme.

The MoJ work closely with health partners to co-ordinate work on tackling the harm caused by NPS and other substance misuse, and to provide staff with the tools and information to tackle this issue in their work with offenders. There is an ongoing campaign to ensure that all prisoners are aware of the very serious risks that NPS bring. This has included a prison radio campaign, harm reduction posters, leaflets and a DVD, and focus groups and local initiatives in many prisons.

In July 2015, the PPO reported on 19 deaths which occurred in prison between April 2012 and September 2014, where the prisoner was known or strongly suspected to have been using NPS-type drugs before their death (Prisons and Probation Ombudsman, 2015). The PPO called for better education of both prisoners and prison staff regarding the signs that someone may be using NPS and the potentially harmful effects of such substances.

Scotland

The SPS is currently developing a national strategy and action plan to respond to prisoners under the influence of NPS. This includes developing a protocol on the management of prisoners under the influence of NPS who are demonstrating challenging behaviour including 'excited delirium', and the roll out of a national NPS staff training programme. SPS is also working collaboratively with NHS Health Boards to support the development of a clinical response in line with the Project NEPTUNE guidance.

During 2015 the SPS in partnership with Crew, a third sector organisation who are experts in the field of NPS misuse delivered an NPS (training the trainers) training package to SPS staff, which will provide staff with the knowledge and skills to deliver awareness sessions to colleagues and prisoners on NPS.

8.7.2 Legislation

In January 2015 the *Criminal Justice and Courts Act 2015* (Her Majesty's Government, 2015a) provided additional powers to prison governors to test for non-controlled drugs, such as NPS, in MDT, and to impose stiffer penalties on those suspected of being involved in smuggling NPS into prisons. New sanctions include 'closed visits' (no contact with partners or children), extended or further sentences, solitary confinement, forfeiture of prison wages and/or privileges and being moved to a higher security prison.

Further, in March 2015 the *Serious Crime Act 2015* (Her Majesty's Government, 2015b) was enacted which made it an offence to throw any article or substance in to a prison. Those found guilty could face up to 12 months in jail, or a fine or both for a summary conviction or up to two years in jail, or a fine or both for an indicted conviction.

The *Offender Rehabilitation Act 2014* (Her Majesty's Government, 2014) came into force on 1 February 2015. At this time new providers became responsible for each of the 21 CRCs, who supervise low to medium risk offenders following their release. Throughout 2015 Payment by Results will be rolled out across these services, which will need to reduce both the number of offenders who reoffend and the number of further offences committed by each offender in order to achieve full payment.

The *Health Act 2006* (Her Majesty's Government, 2006) brought in a total smoking ban in enclosed public places in England on 1 July 2007 (similar bans had already been implemented throughout the rest of the UK). Whilst prisons were exempt from this ban and prisoners remained able to smoke inside their cells, in January 2016 a full smoke free policy is to be implemented in all prisons in Wales and at four sites in England (HMPs Exeter, Channing Wood, Dartmoor and Erlestoke). This is part of a phased approach to make all prisons smoke free. E-cigarettes are available to buy in prisons and nicotine replacement therapy (NRT) products can be obtained on prescription through prison health services. Smoking will still be allowed outdoors.

8.7.3 Licence conditions

On 1 November 2014 two new licence conditions and supervision requirements, the Drug Appointment Condition and the Drug Testing Condition, became available to manage offenders in the community following their release through PSI 32/2014. The Drug Appointment condition requires those who have been receiving drug treatment in prison and whose use is associated with dependence to attend an appointment at a community treatment service upon release. Whilst the appointment is mandatory, entering treatment is not. This condition can be applied to any offender with drug misuse issues and is not limited to those misusing class A or B substances.

The Drug Testing Condition should only be applied to offenders whose use of a specified class A or class B drug "caused or contributed to an offence of which the offender has been convicted or is likely to cause or contribute to the commission of further offences by the offender". The decision of what to test for and how frequently is made by the offender's case worker. Refusal by the offender to take a test constitutes a breach of the condition, whilst a positive test result should instigate consideration of a breach of the Good Behaviour Condition of their licence.

8.7.4 Guidelines

A new toolkit designed to support prison healthcare and custody staff on tackling the growing NPS problem has been developed by PHE. This was published in January 2016, and will be supported by a training programme.

Guidance on the clinical management of substance misuse in prisons is currently being reviewed and updated to reflect changing patterns of drug use and to keep pace with the learning from recent reviews of unclassified deaths in custody and emerging best practice. This work will pick up issues around opioid substitution therapy, including for example the use of methadone and Subutex® (buprenorphine), and also the use of naloxone, which may be provided by clinicians when someone leaves prison to mitigate the risk of overdose.

9. Drug markets

9.1 Introduction

Most of the identified drug supply chains to the United Kingdom (UK) follow well-established trafficking routes. Heroin originates from Afghanistan and is transited through either Pakistan or Iran. Cocaine is produced in Colombia, Peru and Bolivia with Spain and the Netherlands being the main transit hubs within Europe for cocaine en route to the UK. The Netherlands is the most significant source for traditional synthetic drugs such as ecstasy and amphetamine, while China is where most new psychoactive substances (NPS) bought online originate. There is domestic production of high potency cannabis within the UK although most cannabis comes from abroad, with Africa and the Caribbean being the main sources for herbal cannabis, whilst resin mainly originates from Morocco and Afghanistan. Branded 'skunk' is imported from the Netherlands.

The restricting supply strand of the UK *Drug Strategy 2010, Reducing demand, restricting supply, building recovery: supporting people to live a drug free life* (Her Majesty's Government, 2010) aims to make the UK an unattractive destination for drug traffickers. The *Serious and Organised Crime Strategy (Her Majesty's Government, 2013b)* focuses, with regard to drugs, on: restricting the supply to the UK; engaging international partners to help disrupt OCGs smuggling illicit drugs through the UK's borders; and ensuring the retrieval of the proceeds and assets from the crimes these groups commit. The strategy coincided with the launch of the new National Crime Agency (NCA).

Cannabis is the most commonly seized drug in the UK. Seizures of herbal cannabis increased in England and Wales alongside an increase in recorded cannabis possession offences following the introduction of cannabis warnings in England and Wales in 2004, although the quantity seized did not show a corresponding rise. Having risen steadily since 2004, the number of cannabis plant seizures dropped in 2013/14, with the quantity of plants seized having already been falling since 2010/11 (perhaps indicative of the trend towards smaller production sites).

Having been low during both 2011 and 2012, heroin domestic resale purity has risen over the last two years and is now higher than in 2010. Cocaine powder purity has increased in recent years returning to levels seen around ten years ago.

9.2 Supply to and within the country

The commentary provided below is based on correspondence with the NCA.

9.2.1 Domestic production

Cannabis

The production of the types of cannabis commonly referred to as 'skunk' continues to be widespread within the UK, with control by white British males most prevalent. Although the exploitation of persons subject to human trafficking and illegal immigration continues to occur, the representation of south-east Asian nationals within UK cannabis production sites is declining. OCGs are known to operate production sites and the supply of cannabis with other commodities (such as cocaine and MDMA/ecstasy) is also common.

The scale of commercial production sites ranges from those located in small dwellings to large scale converted commercial premises with the capacity for thousands of plants. Most production sites encountered by law enforcement are dwelling house conversions, commonly with rooms within a property being fitted for stages of production; ranging from seedling/cutting propagation, to developing plants and for those in final/harvest stages. Sophisticated lighting and ventilation systems are common, with UK-based outlets continuing to supply equipment ostensibly for legitimate horticultural purposes. Grow sites will also commonly provide a 'drying room' to prepare the harvested plants for distribution.

The most common yield per plant ranges from a dry weight of 28 grams to 84 grams, although there are many examples of plants capable of at least 200 grams. When measuring yield, only the bud/head of the plant is calculated, with the leaves being discarded. Although initial set up costs can run into thousands of Great British Pounds (GBP), cannabis production remains highly profitable to those doing so on a commercial scale, with rolling cycles.

There remains a UK interest in production of 'branded' skunk (types developed in the Netherlands, designed to provide the user with a range of experiences and tastes); however, non-branded skunk remains most common. The branded options often achieve price premiums within a connoisseur and experimental market place.

The term 'hydroponics' is overused to describe cannabis production in the UK, with the majority of sites continuing to use a system involving the plants being potted/otherwise contained, with roots within a substrate. These are better described as 'intensive grow sites', due to the lighting and environmental systems creating ideal growing conditions for 10 to 12 week cycles.

Amphetamine Sulphate

The conversion from base to sulphate is becoming an established trend in the UK, with only limited examples of production from precursors being encountered. British OCGs are importing liquid amphetamine oil and wet base into the UK to be converted into amphetamine sulphate. This requires much less expertise, chemicals and equipment than is required for production from precursors, but does offer degrees of control over quality and more diverse opportunities to conceal trafficking into the UK (utilising legitimate containers to conceal liquid rather than powder format amphetamine sulphate). This activity is most common in the north-east through direct links to supply sources in the Netherlands and Belgium.

9.2.2 Drug trafficking routes for imported drugs

Cocaine

Cocaine destined for the UK is produced in Colombia, Peru and Bolivia. Primary exit points from the region for UK-bound cocaine include Ecuador, Peru, Brazil, Venezuela and Guyana. Shipping out of Costa Rica and Panama is also encountered. Concealments within shipping freight, yachts, other maritime vessels, air freight and by air passengers remains common from this region.

Distribution from the Caribbean remains common, from islands including Trinidad and Tobago, those within the Eastern Caribbean, Jamaica and Dominican Republic. Activity involving air passenger couriers and yachts is commonly engaged by OCGs.

West Africa remains a significant transit hub for cocaine destined for the UK, with countries including Ghana and Nigeria remaining significant. South Africa is also a key transit location with traffickers utilising the cover of air and sea facilitated trade routes and legitimate consignments. Cape Verde is a relevant maritime staging post for trans-Atlantic movement of cocaine towards the UK.

Primary entry into Europe for UK-bound cocaine is via Spain, Belgium and the Netherlands, with north-east, east, south-east and south coast ports being the most common access points to the UK from near-Europe. The Netherlands and Spain are the most influential hubs for onward distribution to the UK.

Heroin

Heroin destined for the UK originates principally from Afghanistan, transiting through either Pakistan or Iran (depending upon the onward direction of travel). Some UK-bound heroin may also arrive into the European Union (EU) via Ukraine, having travelled north from Afghanistan through Central Asia.

Heroin that comes to the UK via Pakistan is sent directly by air freight and air passengers as well as via East Africa, having travelled south through the Indian Ocean.

Heroin destined for the UK entering the EU from Turkey tends to transit via Iran, Iraq and smaller land mass countries to the north/east of Turkey. The Balkan Routes are the most common for heroin conveyed in goods vehicles entering the UK either direct from France via south coast ports or having entered and been redistributed in the Netherlands.

The UK is most commonly accessed using 'roll on-roll off' haulage, commercial and private vehicles via south-east and north-east coast ports, with heroin concealed within vehicle structures, cavities and consignment loads.

Amphetamine and MDMA/Ecstasy

The Netherlands is the primary source for traditional synthetic drugs imported into the UK, with points of entry via the north-east, east and south-east ports being most common, either direct from the Netherlands or via France.

Cannabis (high potency/skunk)

The Netherlands remains the primary source for skunk cannabis imported into the UK, with points of entry via the north-east, east and south-east ports being most common, either direct from the Netherlands or via France.

Cannabis (other herbal)

The most common sources include South Africa, West Africa and the Caribbean, and are most frequently imported directly into the UK via maritime freight vessels and containers.

Cannabis (resin)

Morocco and Afghanistan are the primary sources for cannabis resin to the UK. Moroccan resin tends to travel through road routes via Spain and France, but with many examples of direct movement via maritime freight into the UK. The Netherlands is a hub for cannabis resin destined for the UK, with south-east ports being the primary UK access points. Afghan resin tends to follow traditional heroin routes into the UK.

New psychoactive substances

NPS are commonly ordered via the internet and then shipped into the UK from sources in China, or via European hubs, believed to be in use to hold larger consignments. These are broken down to supply individual on-line orders and most commonly despatched via the fast parcel system to the UK.

9.2.3 Drug trafficking within the country

The UK drug market is exploited by a very diverse demographic of drug dealers/distributors of a wide range of nationalities.

The cocaine trade is currently heavily influenced by Albanian-controlled organised crime, utilising other nationals to assist with trafficking logistics. British OCGs and those of other nationalities also continue to be involved. The heroin trade remains influenced by traffickers with Turkish and British Pakistani origin, but also by Albanian and White British OCGs. Nigerian and Ghanaian OCGs are influential concerning West Africa-based trafficking into the UK.

There are established markets in the UK for cocaine, heroin, crack cocaine, amphetamines, ecstasy/MDMA powder, NPS and various types of cannabis. Crack cocaine and NPS wholesale batches tend to be relatively small (often under a kilogram (Kg) per transaction). Other substances are commonly traded in single, multiple, tens and even hundred plus Kg batches.

Unit sizes commonly reflect traditional and long established unit weights of Kg, part (1/4 or 1/2) Kg, ounce (28 grams) and fractions of an ounce (1/2, 1/4, 1/8 and 1/16), then grams and part grams (0.1 and 0.2). In many cases (for powder drugs) division and adulteration are combined to extend profit margin opportunities.

Drugs are concealed in many ways during domestic distribution, although a recent increase in vehicle concealments (as those encountered at ports) has been noted.

An established supply trend has developed involving urban gangs distributing user quantities of heroin and crack cocaine into country and coastal towns and cities from central hubs. These gangs acquire drugs from OCGs, send 'runners' out to establish markets in wider locations and then exploit young and vulnerable people to facilitate onward supply and safe houses. This activity is all facilitated via a 'line' often branded (with a nickname) to the gang in question. The 'line' is a trusted mobile phone number which is accessed by customers having been introduced by a runner. This facilitates a 24-hour demand and supply market, with the mobile phone commonly being isolated in an urban location, with runners able to respond to requests upon demand. By no means the only urban hub, London represents the most prolific.

9.3 Prices and purity

9.3.1 Market influences

The value of the GBP against the United States Dollar (USD) and Euro is an important factor in drug market trends, as both cocaine and heroin are traded in these currencies en route to the UK and within distribution hubs accessed by OCGs supplying the UK. When the value of the GBP drops, no market adjustment is made by suppliers to UK/UK based customers, hence less spending potential following exchange and greater wholesale outlay leads to reduced profit margins. This has previously generated UK domestic wholesale price increases.

Substantial upstream cocaine seizures in Latin America, Caribbean, Caribbean Sea, Atlantic, West Africa and near Europe of major consignments destined for Europe and the UK have historically generated temporary shortages in some areas of the domestic market. This has combined with GBP market strength changes and also resulted in increases in UK wholesale prices. Wholesale suppliers counter this by bulking wholesale amounts (often re-pressing them into new diluted quality blocks) with cutting agents such as benzocaine, reducing retail quality through supply chains, but not increasing retail price.

9.3.2 Wholesale drug market prices

The Kg remains the most common wholesale trading weight for all solid and powder drugs with the exception of crack cocaine which is packaged following domestic conversion. As such, an ounce (28 grams) has become the most frequently encountered trading unit, with each ounce capable of making 280 x 0.1 gram 'rocks'.

Tablet and paper tab drugs, such as ecstasy and LSD, are most commonly traded in 1,000, 5,000 and 10,000 unit batches at wholesale.

Common per Kg prices include:

- Cocaine £36,000 to £45,000
- Heroin £25,000 to £30,000
- Amphetamine £2000 to £4000
- Cannabis Resin £1000
- Cannabis Skunk £4000 (standard) to £8000 (for branded)

These prices reflect what is likely to be paid when acquiring a one Kg unit and take no account of the discount available for multiple unit consignments.

9.3.3 Street-level price data from law enforcement sources

Street/retail deals tend to be in one gram units for cocaine, amphetamine, MDMA, NPS, ketamine and high quality skunk cannabis, with other cannabis types typically being sold for 1/8th ounce (3.5 grams). Heroin and crack cocaine are commonly sold as 'bags' and 'rocks' respectively, in 0.1 gram and 0.2 gram deals.

Street-level price data from law enforcement sources suggest that the price of most drugs remained stable in 2014 (Table 9.1). However, the retail price of cannabis resin and sinsemilla both rose by over 55% from £3.00 and £8.50 per gram in 2013 respectively to £5.20 and £15.20, respectively, in 2014. The price of ecstasy also rose between 2013 and 2014 from £3 to £5 per tablet, whilst the typical MDMA content per pill fell from 102g in 2012 to 90g in 2014.

9.3.4 Purity of drugs and composition of drugs/tablets in the domestic market

From forensic insight, the majority of adulteration tends to take place before the drug reaches the 'street dealer'. Their means of profit-making will more often be division and reduction in deal size for the very small amounts. For example, if a street dealer buys quarter of an ounce of heroin (3.5 grams) and sells in 0.08 gram, rather than 0.1 gram deals, this will provide 44 deals at £10, instead of 35 deals; an additional return of £90 from a very small amount.

Until 2007 drug purity data were provided by the Forensic Science Service (FSS). Following the growth of private forensic services, in 2008 and 2009 data were combined with data from the second largest provider, LGC Forensics. In December 2010 it was announced that the FSS was to be closed down by the end of March 2012 with the Serious Organised Crime Agency (SOCA) taking custodianship of the national drugs intelligence function. Data for 2010 onwards has been provided by SOCA/NCA from an expanded number of forensic agencies. The data are collected from tests conducted on police seizures within the domestic market including seizures of packages at one or two stages above street-level. As such, the mean purities reported for substances may be higher than if data were based on street-level seizures alone.

Table 9.1: Law enforcement agencies: Typical price of street level illicit drugs in the United Kingdom, 2006 to 2014

DRUG	PRICE PER GRAM EXCEPT WHERE OTHERWISE STATED								
	2006	2007	2008	2009	2010	2011	2012	2013	2014
	EXCH. RATE: £1=€1.467	EXCH. RATE: £1=€1.4619	EXCH. RATE: £1=€1.2588	EXCH. RATE: £1=€1.1233	EXCH. RATE: £1=€1.1752	EXCH. RATE: £1=€1.1462	EXCH. RATE: £1=€1.2337	EXCH. RATE: £1=€1.2542	EXCH. RATE: £1=€1.2386
Amphetamines	£9.00	£9.00	£10.00	£10.00	£10.00	£10.00	£10.00	£10.00	£10.00
	€13.20	€13.16	€12.59	€11.23	€11.75	€11.46	€12.34	€12.54	€12.39
Cannabis herb*	£2.68	£2.70	£2.85	£2.85	£2.82	£5.00	£5.00	£3.00	£2.90
	€3.93	€3.95	€3.59	€3.20	€3.31	€5.73	€6.17	€3.76	€3.59
Cannabis resin*	£2.12	£2.82	£2.85	£2.85	£2.82	£5.00	£5.00	£3.00	£5.20
	€3.11	€4.12	€3.59	€3.20	€3.31	€5.73	€6.17	€3.76	€6.44
Cannabis (sinsemilla)*		£6.21	£5.63	£7.15	£7.15	£10.00	£10.00	£8.50	£15.20
		€9.08	€7.09	€8.03	€8.40	€11.46	€12.34	€10.66	€18.83
Cocaine powder	£49.00	£46.00	£40.00	£40.00	£40.00	£40.00	£40.00	£40.00	£40.00
	€71.88	€67.24	€50.35	€44.93	€47.01	€45.85	€49.35	€50.17	€49.54
Crack cocaine†	£18.00	£65.00	£65.00	£60.00	£50.00	£50.00	£60.00	£60.00	£60.00
	€26.41	€95.02	€81.82	€67.40	€58.76	€57.31	€74.02	€75.25	€74.31
Ecstasy (per tablet)	£3.00	£3.00	£3.00	£2.50	£2.50	£5.00	£3.00	£3.00	£5.00
	€4.40	€4.39	€3.78	€2.81	€2.94	€5.73	€3.70	€3.76	€6.19
Heroin	£52.00	£48.00	£45.00	£45.00	£45.00	£40.00	£40.00	£50.00	£50.00
	€76.28	€70.17	€56.65	€50.55	€52.88	€45.85	€49.35	€62.71	€61.93
LSD (per dose)	£3.00	£3.50	£3.00	£3.00	£3.00	-	-	£3.00	£3.00
	€4.40	€5.12	€3.78	€3.37	€3.53	-	-	€3.76	€3.72
Mephedrone					£10.00	£20.00	£20.00	£15.00	-
					€11.75	€22.92	€24.67	€18.81	-
Ketamine					£25.00	£25.00	£20.00	£20.00	£20.00
					€29.38	€28.66	€24.67	€25.08	€24.78

*Before 2007 the cannabis values were based on the price per ounce. In 2007 this changed to being based on a usual street deal of 1/8oz and the price was converted to gram equivalent. In 2011 prices were reported on a gram basis.

†Crack cocaine prices before 2007 were provided per rock (0.2g) not per gram. Prices after 2007 cannot be compared to earlier prices.

Source: ST16

Data on cannabis potency are not provided due to concerns about the representativeness of samples submitted for forensic analysis. A cannabis potency study was carried out in 2008 (Home Office, 2008). No further study has been carried out. Purity data are shown in Table 9.2 and commentary is provided by individual drug.

Amphetamines

The typical domestic resale purity of amphetamines continued to rise following a small rise in from five per cent in 2012 to seven per cent in 2013, and in 2014 reached 12%, a level higher than at any other time in the last decade. Almost all amphetamines seized are cut with caffeine, while other common diluting agents include lactose and glucose.

Table 9.2: Domestic resale mean percentage purity of certain drugs seized by police in England and Wales, 2003 to 2014

DRUG	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Amphetamines	11	9	10	11	11	8	8	8	10	5	7	12
Cocaine powder	51	42	43	35	33	29	20	24	26	37	38	36
Crack cocaine	70	64	65	50	52	43	27	31	26	30	36	37
Ecstasy*	65	67	66	48	52	33	44	49	71	102	n/a	90
Heroin (brown)	33	40	47	44	50	43	44	35	18	20	29	36

*mg of MDMA base per tablet

Source: ST14

Cocaine

Cocaine entering the UK tends to be either adulterated or sold at premium prices as high quality. When adulterated, it is not unusual for (as an example) 80% pure to become 40% through a 1:1 ratio mix with the most common cutting agent, benzocaine. It is not unusual for a total reduction to take place down to about 20% for street level supply, with the adulteration not always occurring at a single stage of the supply chain.

The average purity of cocaine powder in the domestic market has fallen slightly for the first time in five years from 38% in 2013 to 36% in 2014. However, it still remains over one and half times higher than the level seen in 2009 (20%). Conversely, in the last year purity-adjusted price has risen for the first time in five years and is now more expensive when taking purity into account than in the indexed year (Table 9.3). Levamisole is commonly detected in wholesale cocaine seizures (added at the point of production) while benzocaine is used to bulk out the product within the UK. Other adulterants detected by forensic agencies include caffeine and phenacetin.

Purity of crack cocaine followed a similar pattern to that of cocaine in powder form, reducing between 2003 and 2009, although the purity of crack cocaine remained higher over this period. The increase in purity of crack cocaine since 2009 has been less pronounced than that of cocaine powder, having risen to 37% in 2014.

Table 9.3: Purity-adjusted price of heroin and cocaine per gram in the United Kingdom, 2003 to 2013: indexed to 2003

YEAR	HEROIN	COCAINE
2003	£62.00	£55.00
2004	£45.08	£61.58
2005	£37.97	£58.75
2006	£39.09	£72.70
2007	£31.52	£70.94
2008	£34.46	£71.11
2009	£33.11	£100.89
2010	£42.16	£86.05
2011	£74.32	£78.17
2012	£65.40	£55.65
2013	£49.55	£53.89
2014	£45.52	£56.89

Source: ST14 and ST16

Heroin

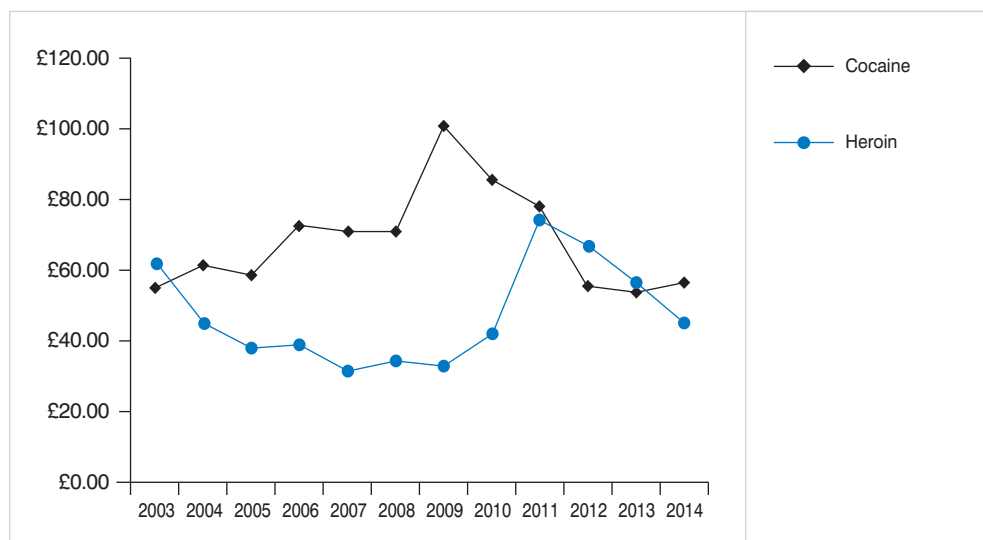
Paracetamol is the main cutting agent used for bulking heroin although it is also adulterated with caffeine. In most cases a blend of the two (cooked brown to mimic the colour) is used.

The quality of heroin imported to the UK tends to vary to a greater degree than cocaine. This generates a dynamic where those less informed of source, trafficker reputation and production quality are not aware of the domestic quality of heroin they have purchased. This results in domestic suppliers 'doing what they do' regarding adulteration, generating a lottery to street dealers and users alike concerning the strength of drug they supply and consume. Although retail prices remain stable, the purity of a £10 bag (0.1 gram) has the potential to range from five per cent to 50%. High strength drugs are potentially more dangerous than poor quality — particularly if a user has built a tolerance to heroin of a fairly consistent (lower) purity.

After a large decrease in the purity of street-level heroin between 2010 and 2011, which was largely sustained in 2012, the purity of this drug rose sharply to 29% in 2013, and continued to rise to 36% in 2014 (Table 9.2). This possibly indicates a potential resurgence in the quantity of heroin arriving in the UK and the quality being targeted on UK markets. Despite the increase in the price per gram at street-level, the purity-adjusted price has fallen considerably from a peak around £74 per gram in 2011 to around £45 in 2014 (Table 9.3) as a result of the increased quality of the substance typically being sold at street-level. However, in 2014, heroin remains more expensive than it had been for several years prior to 2010 when adjusting for purity.

Figure 9.1 shows that the purity-adjusted price of cocaine powder and heroin had been at a similar level in 2003, after which they took divergent paths with cocaine being the more expensive. They returned to similar levels between 2011 and 2013; however, in the last year the purity-adjusted price of heroin has continued to fall whilst that of cocaine has risen slightly. It is too early to say whether this is the beginning of a trend.

Figure 9.1: Purity-adjusted price of cocaine powder and heroin per gram in the United Kingdom, 2003 to 2014: indexed to 2003



*Since 2008 data have been received from more forensic providers

Source: ST14 and ST16

9.4 Drug supply reduction activities

9.4.1 Key priorities of supply reduction

The UK *Drug Strategy 2010, Reducing demand, restricting supply, building recovery: supporting people to live a drug free life* (Her Majesty's Government, 2010) was published in December 2010. The strategy is divided into the three broad themes of reducing demand, restricting supply and building recovery, each with a number of objectives and proposed actions. The restricting supply strand aims to make the UK an unattractive destination for drug traffickers.

The strategy set out a number of objectives for reducing the supply of illicit substances including:

- law enforcements reforms, such as the introduction of Police and Crime Commissioners (PCCs) and the NCA;
- integrated local enforcement;
- reducing drug supply in prisons;
- sharing intelligence to increase understanding of who is involved in organised crime;
- monitoring the NPS market through the development of a Forensic Early Warning System (FEWS) and restricting their supply through the introduction of TCDOs;
- reduce the trade of substances via UK websites in violation of the Misuse of Drugs Act 1971;
- increasing the number of money laundering prosecutions relating to drug-related offences and increasingly disrupting criminal finances;
- reducing the trade in cutting agents and precursor chemicals through new powers to seize supplies; and
- strengthening relations with overseas partners to tackle the international drugs trade

The UK *Serious and Organised Crime Strategy (Her Majesty's Government, 2013b)* was published in October 2013 and coincided with the launch of the new NCA. It reflects the changes to the threats the UK faces, targeting national and international serious and organised crime with the aim to substantially reduce it. The strategy uses the framework developed for counter-terrorist work and has four components: prosecuting and disrupting people engaged in serious and organised crime (Pursue); preventing people from engaging in this activity (Prevent); increasing protection against serious and organised crime (Protect); and reducing the impact of this criminality where it takes place (Prepare). On illicit drugs, the strategy particularly focuses on restricting the supply to the UK, engaging International partners to help disrupt OCGs smuggling illicit drugs through UK borders and ensuring the retrieval of the proceeds and assets from the crimes these groups commit.

9.4.2 Areas of activity of supply reduction

In the last year, progress towards restricting supply has included several pieces of new legislation: the *Serious Crime Act 2015* (Her Majesty's Government, 2015b) introduced powers for law enforcement to tackle the trade in cutting agents, driving up the cost and risk for organised criminals; the strengthening of the *Proceeds of Crime Act* ((Her Majesty's Government, 2002) enabled assets to be frozen and recovered, and traffickers prosecuted more quickly; a number of NPS and prescription medicines were permanently controlled under the *Misuse of Drugs Act 1971* (Her Majesty's Government, 1971); and a new drug-driving offence was enacted (see section 2.2.1). In addition, guidance documents were published for local authorities and the police to advise them of the powers available to them to reduce the supply of NPS through head shops (Home Office, 2015h) (see section 2.2.3). The Psychoactive Substances Bill has been introduced in Parliament and, subject to Parliamentary approval, this legislation will ban the sale, supply, production and distribution of psychoactive substances for human consumption.

In order to restrict the supply of illicit drugs, future work will include: a crackdown on UK-based websites in violation of the Misuse of Drugs Act 1971; an evaluation of the five new Joint Border Intelligence Units and, if successful, the roll out of further units; and increased access to centralised data on drug testing on arrest to enable the identification of local trends.

9.4.3 Organisational structures/co-ordinating bodies

Home Office

The Home Office is the department with lead responsibility for the co-ordination of the delivery of the Drug Strategy on behalf of the Government, and publishing annual reviews detailing the progress made towards the strategy's objectives.

Border Force

Based within the Home Office, Border Force secures the UK border by carrying out immigration and customs controls for people and goods entering the UK. This includes searching baggage, vehicles and cargo for illicit goods, patrolling the UK coastline and searching vessels, gathering intelligence and alerting the police and security services to people of interest.

National Crime Agency

The NCA, formerly SOCA, became operational in October 2013. They are a non-ministerial government department, accountable to the Home Secretary. They work with the police, Border Force and international collaborators to lead the UK law enforcement's fight to cut serious and organised crime. This includes restricting the supply of drugs trafficked into the UK.

Police and Crime Commissioners

Established under the Drug Strategy 2010, PCCs are elected officials with the responsibility of securing efficient and effective policing in their area.

9.5 Seizures

9.5.1 Drug seizures in the United Kingdom in 2013/14

The total number of seizures across the UK remained stable from 2012/13 to 2013/14, dropping 1.5% from 231,720 to 228,250.

There was an increase in the number of seizures for all drugs, except cannabis and mephedrone (Table 9.4). The number of ketamine seizures in the UK rose 18% from 2012/13 due to an increase in seizures in England and Wales. Over the same time period, the number of cocaine powder and crack cocaine seizures rose by 6.6% and 5.0% respectively.

Table 9.4: The number of seizures of individual drugs in the United Kingdom by country in 2013/14 and percentage change from 2012/13

DRUG	ENGLAND AND WALES	SCOTLAND	NORTHERN IRELAND*	UK	% CHANGE FROM 2012/13
Amphetamines	6,067	562	96	6,725	2.8
Cannabis – herbal	130,045	14,205	3,059	147,309	-0.9
Cannabis – resin	6,803	6,702	600	14,105	-18.8
Cannabis plants	14,501	998	245	15,744	-0.6
Cocaine powder	16,825	2,565	430	19,820	6.6
Crack cocaine	4,746	151	-	4,897	5.0
Ecstasy type substances	3,237	549	127	3,913	4.8
Heroin	8,579	2,302	32	10,913	2.5
Ketamine	1,621	26	3	1,650	15.8
Mephedrone*	2,882	61	135	3,078	-24.9

*Police seizures only

Source: ST13

As with previous years, cannabis was by far the most commonly seized drug (approximately 177,000 seizures in total), involved in around nine times as many seizures as cocaine powder, the next most commonly seized drug. However, the number of seizures of all types of cannabis dropped in the last year (a decrease of almost 10%). The largest fall within types of cannabis was observed in cannabis resin; down 18.8% on the number of seizures in the previous year.

Unlike the numbers of seizures, the quantity of some drugs seized changed substantially between 2012/13 and 2013/14 (Table 9.5). The largest decrease was seen for cannabis resin which fell steeply by 91.6%, driven by a substantial decrease in the quantity seized in England and Wales.

With a rise of 7.1%, the amount of cocaine powder seized increased almost in line with the number of seizures (6.6%). However, changes in one measure are not always reflected in the other. For example, despite the 0.9% reduction in numbers of herbal cannabis seizures, the quantity seized rose by 41.2%. Inversely, despite the small increase in seizures of ecstasy-type substances, the quantity of tablets seized decreased by 10.1%. The quantity of ketamine seized saw the largest increase between 2012/13 and 2013/14, rising 46.3%, which was again driven by changes to the amount seized in England and Wales.

Table 9.5: The quantity of individual drugs seized in the United Kingdom by country in 2013/14 and percentage change from 2012/13

DRUG	UNIT	ENGLAND AND WALES	SCOTLAND	NORTHERN IRELAND*	UK	% CHANGE FROM 2012/13
Amphetamines	Kg	1217.0	504.9	8.2	1730.1	16.1
Cannabis – herbal	Kg	17,953.0	452.7	299.3	18,705	41.2
Cannabis – resin	Kg	735.0	367.8	30.8	1,133.6	-91.6
Cannabis plants	Plant	451,154.0	23,336.0	10,155.0	484,645.0	-12.8
Cocaine powder	Kg	3,412.0	124.3	25.2	3,561.5	7.1
Crack cocaine	Kg	48.0	2.3	-	50.3	8.2
Ecstasy type substances	Tablet (000s)	399.0	15.7	8.3	423.0	-10.1
Heroin	Kg	642.0	142.8	0.1	784.9	-5.6
Ketamine	Kg	355.0	0.1	2.1	357.2	46.3
Mephedrone**	Kg	84.0	66.8	3.6	154.4	-45.6

*Police seizures only

**Powder only

Source: ST13

9.5.2 Trends in drug seizures in England and Wales

As UK drug seizure data have not been available on a consistent basis in the past six years, data from England and Wales are used to comment on trends. Cannabis has remained the most commonly seized drug throughout this period (Home Office, 2014b). The number of seizures of herbal cannabis increased substantially between 2004 and 2008/09, while the quantity of herbal cannabis seized remained stable (Table 9.6; Table 9.7). Over this period there was also a large rise in recorded possession offences (see section 2.3.2). As quantities seized resulting from possession offences are typically small, the lack of a corresponding rise in quantity of herbal cannabis seized may indicate that the rise in numbers of seizures was primarily due to increased possession offences.

The quantity of heroin seized over the last decade has varied greatly year on year. Following a low in 2010/11 (which may have been indicative of the reduction in the availability of heroin widely regarded to have affected the market during this period) (European Monitoring Centre for Drugs and Drug Addiction, 2013) the quantity of heroin that was seized more than doubled in 2011/12. However, it has since fallen by more than 65% and in 2013/14 was at a level lower than that which had been seen in 2010/11. Seizures of ecstasy tablets, which similarly increased greatly in quantity from 2010/11 to 2011/12, have also returned to levels comparable to those reported in 2010/11. Such variation between years in the quantity of drugs seized may reflect varying law enforcement activity between years and should not be assumed to directly reflect the availability, or indeed use, of these substances.

Table 9.6: Number of seizures of drugs by police forces and Border Force in England and Wales, 2004 to 2013/14

DRUG	2004	2005	2006/07*	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13†	2013/14†
Amphetamines	6,504	7,837	8,477	8,863	7,760	7,302	7,185	6,773	5,758	6,067
Cannabis – herbal	43,072	76,157	109,649	137,526	145,353	144,456	139,237	149,371	136,765	130,045
Cannabis – resin	35,219	41,454	32,590	30,870	35,795	24,339	18,312	14,207	8,234	6,803
Cannabis plants	2,930	4,327	5,805	8,539	9,380	12,920	14,423	16,590	14,597	14,501
Cocaine powder	8,279	12,512	16,917	21,346	24,659	21,377	17,710	17,596	16,664	16,825
Crack cocaine	5,164	6,705	6,955	7,578	6,623	5,081	5,385	4,985	4,581	4,746
Ecstasy	6,256	6,688	8,184	7,173	5,218	3,724	2,537	3,200	3,215	3,237
Heroin	11,668	14,072	13,942	14,186	13,302	12,836	10,821	9,182	8,485	8,579
Benzodiazepines‡	830	1,747	2,261	2,815	4,038	2,957	2,489	2,695	1,997	2,032
Ketamine	-	-	-	-	1,269	1,612	1,793	1,543	1,518	1,621
Total§	112,923	169,802	196,099	228,131	241,473	224,401	212,786	218,721	198,578	192,294

*in 2006/07 data moved to a financial year basis

†excludes Gwent Police

‡These figures relate only to police seizures, and do not include temazepam

§As a seizure can involve more than one drug, figures for individual drugs and drug classes cannot be added together to produce totals

Source: (Home Office, 2014b)

Trends in seizures of cannabis plants over time fluctuate less year on year and reveal long-term trends which may be reflective of market activity. The quantity of plants seized rose steadily and steeply more than eightfold over a five year period from 2004. However, since then fewer plants have been seized in each year and the total quantity seized has fallen by 40% from the peak in 2009/10 to 2013/14. The initial rapid increase may reflect the burgeoning of domestic cannabis production on an industrial scale in the UK. The latter reduction in quantity of plants seized stands in contrast to the trend in the number of seizures of plants, which continued to rise steadily up to 2011/12 only dropping 13% over the last two years and remaining higher than any time prior to 2011/12. The divergence in these trends may be indicative of a shift in domestic production towards use of smaller cultivation sites.

Table 9.7: The quantity of individual drugs seized by police forces and Border Force in England and Wales, 2004 to 2013/14

DRUG	UNIT	2004	2005	2006/07*	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13†	2013/14†
Amphetamines	Kg	1,257	2,091	1,390	1,811	2,939	1,326	711	1,062	1,434	1,217
Cannabis – herbal	Kg	21,535	20,583	25,832	20,093	33,363	17,951	20,693	22,326	12,353	17,953
Cannabis – resin	Kg	63,234	50,591	19,851	16,710	31,799	12,563	18,659	19,478	11,325	735
Cannabis plants	Plant	93,469	220,019	363,679	535,888	643,510	758,943	729,584	639,227	507,438	451,154
Cocaine powder	Kg	4,640	3,821	3,244	3,453	2,916	2,643	2,387	3,461	3,036	3,412
Crack cocaine	Kg	140	51	60	37	33	59	50	35	42	48
Ecstasy	Tablet (000s)	4,740	3,019	6,685	965	547	171	371	663	453	399
Heroin	Kg	2,170	1,907	1,030	1,059	1,552	1,516	732	1,849	752	642
Ketamine	Kg	-	-	-	-	27	293	802	81	244	355

*in 2006/07 seizures data moved to a financial year basis

†excludes Gwent Police

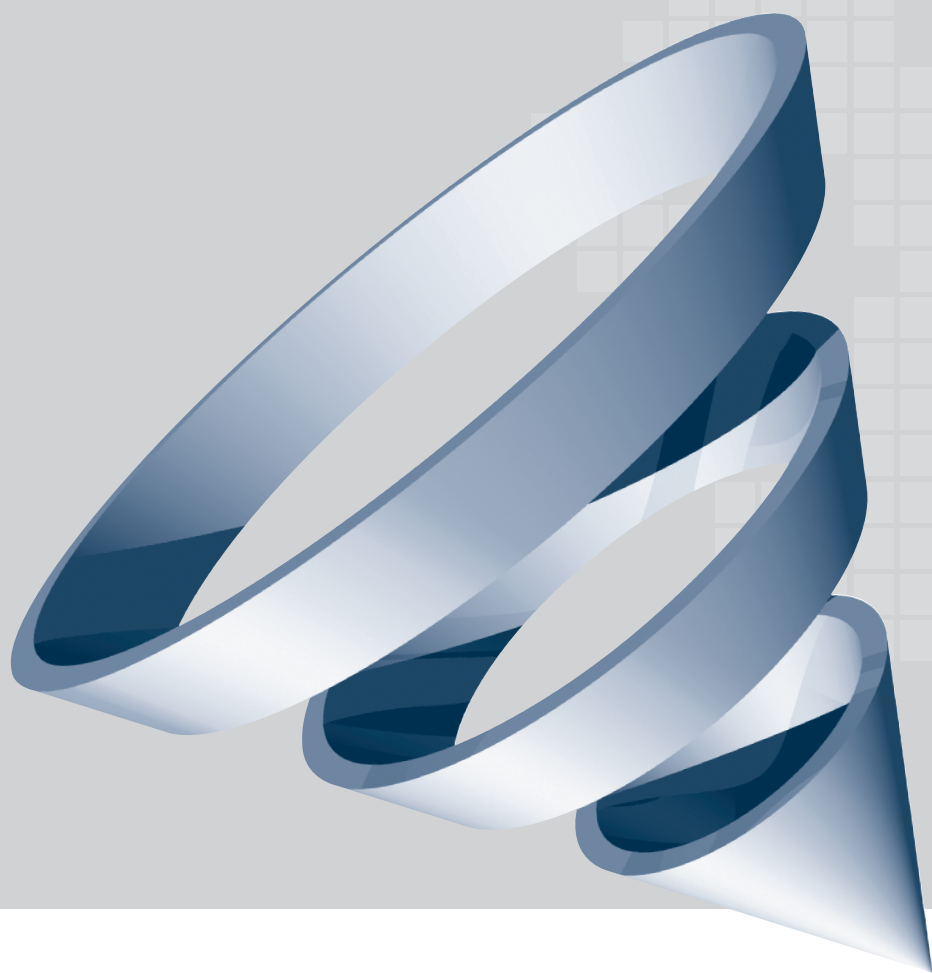
Source: (Home Office, 2014b)

9.5.3 Other seizures data

The Medicines and Healthcare Products Regulatory Agency (MHRA) announced in June 2015 that, as part of a global operation, £15.8 million worth of counterfeit and unlicensed medicines were seized in the UK during a series of raids over a one-week period; almost twice as much as the value of the substances seized in the same operation the previous year.¹³⁹ The majority of the medicines seized in the UK originated from India, China, Hong Kong and Singapore. The operation was part of an international crackdown named Operation Pangea, which was coordinated through Interpol and targeted the illicit online medicine trade. Seizures of substances in the UK accounted for a third (30.6%) of the overall market value of the drugs seized internationally as part of the operation.

¹³⁹ See: <https://www.gov.uk/government/news/uk-leads-the-way-with-158-million-seizure-in-global-operation-targeting-counterfeit-and-unlicensed-medicines-and-devices>

Part B: Bibliography and Annexes



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List of Abbreviations used in the Text

£	Pound sterling (UK)	APT	Addiction Prevalence Test
€	Euro	ASI	Addiction Severity Index
2-DPMP	2-diphenylmethylpiperidine	BBV	Blood-borne Virus
3,4-DCMP	3,4-Dichloromethylphenidate	BCS	British Crime Survey
4,4'-DMAR	4-methyl-5-(4-methylphenyl)-4,5-dihydrooxazol-2-amine	BSR	Building Skills for Recovery
5F-AKB-48	<i>N</i> -(adamantan-1-yl)-1-(4-fluoropentyl)-1 <i>H</i> -indazole-3-carboxamide	BZP	Benzylpiperazine
5F-PB-22	Quinolin-8-yl 1-(5-fluoropentyl)-1 <i>H</i> -indole-3-carboxylate	CAPI	Computer Assisted Personal Interviewing
5-MeO-DALT	<i>N,N</i> -diallyl-5-methoxytryptamine	CASI	Computer Assisted Self Interviewing
ACMD	Advisory Council on the Misuse of Drugs	CCEA	Council for Curriculum, Examinations and Assessment
AD:EPT	Alcohol and Drugs: Empowering People through Therapy	CCG	Clinical Commissioning Group
ADEPIS	Alcohol and Drug Education and Prevention Information Service	CCTV	Closed-Circuit Television
ADP	Alcohol and Drug Partnership	CI	Confidence Interval
AH-7921	3,4-dichloro- <i>N</i> -[(1-dimethylamino)cyclohexylmethyl]benzamide	CJIT	Criminal Justice Intervention Team
AIDS	Acquired Immunodeficiency Syndrome	CJS	Criminal Justice System
ALD-52	1-Acetyl-lysergic Acid Diethylamide	CO	Community Order
AL-LAD	6-Allyl-6-nor-lysergic Acid Diethylamide	CoSLA	Convention of Scottish Local Authorities
AMT	Alpha-methyltryptamine	CPP	Community Planning Partnerships
Anti-HBc	Antibodies to hepatitis B virus	CQC	Care Quality Commission
Anti-HCV	Anti-hepatitis C virus	CRC	Community Rehabilitation Company
APB	Area Planning Board	CSEW	Crime Survey for England and Wales
APoSM	Advisory Panel on Substance Misuse	CSP	Community Safety Partnership
		D2PM	Diphenyl-2-pyrrolidinylmethanol
		DA	Devolved Administration
		DACT	Drug and Alcohol Co-ordination Team

DAISy	Drug and Alcohol Information System	FDAC	Family Drug and Alcohol Court
DBS	Dried Blood Spot	FDT	Failed Drug Test
DCLG	Department for Communities and Local Government	FEWS	Forensic Early Warning System
DENI	Department of Education Northern Ireland	FSS	Forensic Science Service
DfE	Department for Education	FTDC	Family Treatment Drug Court
DH	Department of Health	g	Gram
DHSSPS	Department of Health, Social Services and Public Safety	GBL	Gamma-butyrolactone
DIP	Drug Interventions Programme	GBP	Great British Pounds
DMD	Drug Misuse Definition	GHB	Gamma-hydroxybutyrate
DPH	Director of Public Health	GIRFEC	Getting It Right For Every Child
DRD	Drug-Related Deaths	GMR	General Mortality Register
DRP	Drug-Related Poisoning	GP	General Practitioner
DRR	Drug Rehabilitation Requirement	GPS	General Population Surveys
DRU	Drug Recovery Unit	HBsAg	Hepatitis B surface Antigen
DRW	Drug Recovery Wing	HBSC	Health Behaviour in School Age Children Survey
DSD	Drug Strategy Definition	HBV	Hepatitis B Virus
DSDC	Drugs Strategy Delivery Commission	HCV	Hepatitis C Virus
DTTO	Drug Treatment and Testing Order	HDMP-28	Methylnaphthidate
DWP	Department for Work and Pensions	HEAT	Health improvement, Efficiency and Access Treatment
EASR	European Age-sex Standardised Rate	HIV	Human Immunodeficiency Virus
EDDRA	Exchange on Drug Demand Reduction Action	HJIP	Health and Justice Indicators of Performance
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction	HMCI	Her Majesty's Chief Inspector
ETH-LAD	6-Ethyl-6-nor-lysergic Acid Diethylamide	HMIP	HM Inspectorate of Prisons
EU	European Union	HMP	Her Majesty's Prison
		HNA	Health Needs Assessment
		HRD	Harm Reduction Database
		HRDU	High Risk Drug Use
		HSCIC	Health and Social Care Information Centre
		HWB	Health and Wellbeing Board

ICD-10	International Statistical Classification of Diseases and Related Health Problems-tenth edition	MRSA	Meticillin-resistant <i>Staphylococcus aureus</i>
ICT	Information and Communications Technology	MSM	Men who have Sex with Men
IDU	Injecting Drug Users	MSP	Member of the Scottish Parliament
IPED	Image and Performance Enhancing Drug	MSSA	Meticillin-sensitive <i>Staphylococcus aureus</i>
IPP/IPPD	Isopropylphenidate	MT-45	1-Cyclohexyl-4-(1,2-diphenylethyl)piperazine
IRC	Immigration Removal Centre	MUP	Minimum Unit Price
ISD	Information Services Division	n/a	Not available
JHWS	Joint Health and Wellbeing Strategy	NACD	National Advisory Committee on Drugs
JSNA	Joint Strategic Needs Assessment	NCA	National Crime Agency
Kg	Kilogram	NDRDD	National Drug-Related Deaths Database
L&D	Liaison and Diversion	NDTMS	National Drug Treatment Monitoring System
LA	Local Authority	NEET	Not in education, employment or training
LDP	Local Delivery Plan	NEPTUNE	Novel Psychoactive Treatment UK Network
LGBT	Lesbian Gay Bisexual and Transgender	NFER	National Foundation for Educational Research
LHB	Local Health Board	NHS	National Health Service
LJMU	Liverpool John Moores University	NI	Northern Ireland
LSD	Lysergic Acid Diethylamide	NICE	National Institute for Health and Care Excellence
LSZ	Lysergic Acid 2,4-Dimethylazetidide	NIDMD	Northern Ireland Drug Misuse Database
MDMA	3,4-Methyldioxy-n-methylamphetamine	NIPS	Northern Ireland Prison Service
MDT	Mandatory Drug Testing	NOMS	National Offender Management Service
mg	Milligram	NPIS	National Poisons Information Service
MHRA	Medicines and Healthcare Products Regulatory Agency	NPS	New Psychoactive Substances
MIM	Multiple-Indicator Method		
MoJ	Ministry of Justice		

NPSAD	National Programme on Substance Abuse Deaths	PRO-LAD	6-Propyl-6-nor-lysergic Acid Diethylamide
NRS	National Records of Scotland	PSA	Public Service Agreement
NRT	Nicotine Replacement Therapy	PSHE	Personal, Social and Health Education
NSD	New Strategic Direction	PSI	Prison Service Instruction
NSP	Needle and Syringe Programmes	PSO	Prison Service Order
OCG	Organised Crime Group	PWID	People Who Inject Drugs
OCU	Opioid and/or crack cocaine user	PY	Person Years
ONS	Office for National Statistics	RAPt	Rehabilitation for Addicted Prisoners Trust
OST	Opioid Substitution Therapy/ Treatment	RMDT	Random Mandatory Drug Testing
PASRO	Prisoners Addressing Substance Related Offending	ROW	Recovery Outcomes Web
PbR	Payment by Results	RQIA	Regulation and Quality Improvement Authority
PCC	Police and Crime Commissioner	RSS	Royal Statistical Society
PDMU	Personal Development and Mutual Understanding	SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
PDU	Problem Drug Use	SCDEA	Scottish Crime and Drug Enforcement Agency
PHA	Public Health Agency for Northern Ireland	SCH	Secure Children's Home
PHE	Public Health England	SCJS	Scottish Crime and Justice Survey
PHIRB	Public Health Information and Research Branch	SCRA	Synthetic Cannabinoid Receptor Agonist
PHOF	Public Health Outcomes Framework	SCVS	Scottish Crime and Victimisation Survey
PHPQI	Prison Health Performance and Quality Indicator	SDD	Smoking Drinking and Drug Use Among Young People in England Survey
PHW	Public Health Wales	SDMD	Scottish Drug Misuse Database
PMA	Para-methoxyamphetamine	SEHSCT	South Eastern Health and Social Care Trust
PMMA	Para-methoxy-N-methylamphetamine	SMAF	Substance Misuse Action Fund
PND	Penalty Notice for Disorder	SMNPB	Substance Misuse National Partnership Board
POM	Prescription Only Medication		
PPO	Prisons and Probation Ombudsman		

SMR	Special Mortality Register	THN	Take Home Naloxone
SOA	Single Outcome Agreements	TOP	Treatment Outcomes Profile
SOCA	Serious Organised Crime Agency	TPD	Tobacco Products Directive
SPAR	Supporting Prisoner at Risk	UAM	Unlinked Anonymous Monitoring
SPCR	Surveying Prisoner Crime Reduction	UK	United Kingdom
SPS	Scottish Prison Service	USA	United States of America
SQ	Structured Questionnaire	USD	United States Dollar
SSO	Suspended Sentence Order	VCT	Voluntary Confidential Testing
ST	Standard Table	WEDINOS	Welsh Emerging Drug and Identification of Novel Substances
STC	Secure Training Centre	WHO	World Health Organisation
STIs	Sexually transmitted infections	WNDSM	Welsh National Database for Substance Misuse
TB	Tuberculosis	YOI	Young Offenders Institution
TCDO	Temporary Class Drug Order		
TDI	Treatment Demand Indicator		

List of Standard Tables

NUMBER	TITLE	SOURCE
ST01	Basic results and methodology of population surveys on drug use	England and Wales - <i>Crime Survey for England and Wales</i> (CSEW); Scotland – <i>Scottish Crime and Justice Survey</i> (SCJS); Northern Ireland – <i>Northern Ireland Crime Survey</i> (NICS); <i>Drug Prevalence Survey</i>
ST02	Methodology and results of school surveys on drug use	England – <i>Smoking, Drinking and Drug Use Among Young People in England</i> Scotland – <i>Scottish Schools Adolescent Lifestyle and Substance Use Survey</i> (SALSUS) Northern Ireland – <i>Young Persons' Behavioural and Attitudes Survey</i> (YPBAS) Wales - <i>Health Behaviour in School Age Children Survey</i> (HBSC)
ST05	Acute/direct related deaths	General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland
ST06	Evolution of acute/direct related deaths	General Mortality Registers (GMRs) for England and Wales, Scotland and Northern Ireland
ST07	National prevalence estimates of high risk drug use	Home Office; National Health Service (NHS) Information Services Division (ISD) Scotland; Department of Health Social Services and Public Safety Northern Ireland (DHSSPSNI); Welsh Assembly Government; Public Health England (PHE)
ST09	Prevalence of hepatitis B/C and HIV infection among injecting drug users	Public Health England (PHE); Health Protection Scotland (HPS); Public Health Wales; Public Health Agency Northern Ireland
ST10	Syringe availability	Injecting Equipment Provision (IEP) in Scotland Survey, National Health Service (NHS) Information Services Division (ISD) Scotland; Northern Ireland Needle and Syringe Exchange Scheme; Harm Reduction Database (HRD), Public Health Wales
ST11	Arrests/reports for drug law offences	Ministry of Justice; Scottish Government; Northern Ireland Office; Northern Ireland Police Service (NIPS)
ST13	Number and quantity of seizures of illicit drugs	Home Office; UK Border Force; Scottish Government; Northern Ireland Police Service (NIPS)
ST14	Purity at street level of illicit drugs	National Crime Agency (NCA)
ST16	Price in Euros at street level of illicit drugs	National Crime Agency (NCA)
ST24	Access to treatment	National Drug Treatment Monitoring System (NDTMS) in England; Welsh National Database for Substance Misuse (WNDSM)
ST34	TDI data	National Drug Treatment Monitoring System (NDTMS) in England; Scottish Drug Misuse Database (SDMD); Welsh National Database for Substance Misuse (WNDSM); Northern Ireland Drug Misuse Database (NIDMD)



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